

EXHIBIT 1

GIDEON, COOPER & ESSARY

A PROFESSIONAL LIMITED LIABILITY COMPANY

C. J. GIDEON, JR.¹
 DIXIE W. COOPER²
 BRYAN ESSARY³
 CHRIS J. TARDIO⁴
 CHRISTOPHER A. VRETTOS
 ALAN S. BEAN
 HEATHER D. PIPER
 JAMES C. SPERRING
 JOSHUA R. ADKINS
 KIM J. KINSLER⁵
 RANDA VON KANEL
 J. BLAKE CARTER⁶
 MARK A. HAMMEROVOLD
 ANDREW M. FARRELL
 MATT H. CLINE
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OF COUNSEL:
 LISA YORK BOWMAN⁸

¹LICENSED IN TENN. AND FLORIDA
²LICENSED IN TENN., ALABAMA & TEXAS
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⁴LICENSED IN TENN. AND KENTUCKY
⁵LICENSED IN TENN. AND WISCONSIN
⁶LICENSED IN TENN. AND FLORIDA
⁷LICENSED IN KANSAS
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MATTHEW H. CLINE
matt@gideoncooper.com

July 12, 2013

Lela Hollabaugh
 BRADLEY ARANT BOULT CUMMINGS, LLP
 1600 Division Street, Suite 700
 Nashville, TN 37203

Re: *Medical Records from St. Thomas Hospital*

Dear Lela:

We have received notices of intent for potential lawsuits related to the fungal meningitis outbreak naming STOPNC and/or Howell Allen Clinic as well as St. Thomas Hospital for the following 75 individuals:

<u>Name</u>	<u>DOB</u>	<u>Name</u>	<u>DOB</u>
Alexander, John	/53	Demps, Jerry Ray	/56
Bequette, Ann	/43	Eggleston, Sue	/62
Besaw, Travis	/32	Evans, Danny	/64
Bland, Carolyn	/46	Ferguson, Rosemary	/56
Bratcher, Ben	/78	Glatman, Ellen	/60
Brinton, Laura	/63	Higdon, Shirley	/38
Brock, Denis	/47	Hill, Joanne	/47
Bryant, Margaret	/38	Hurt, Glenda	/49
Burns, Ronda	/62	Johnson, William	/42
Campbell, Barbara	/54	Jordan, Dorris	/57
Carman, Cindy	/71	Kinsey, John	/62
Carroll, Theresa	/49	Kirby, Kelly	/32
Chambers, Kathy	/51	Kirkwood, Joshua	/89
Coleman, Billy Joe	/59	Knight, Betty	/36
Davis, Thomas (Randy)	/46	Koonce, Carol	/39

Ms. Hollabaugh

July 12, 2013

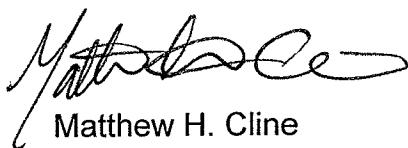
Page 2

Lankford, Charles	/37	Ruhl, Annette	/38
Lemberg, Sondra	/42	Russell, Janet	/41
Lodowski, Patricia	/45	Rybinski, Thomas	/56
Lovelace, Eddie	/34	Sawyers, John	/49
Martin, Mary	/23	Scott, Jimmy M.	/48
Mathias, Herman	/32	Settle, Harvell	/34
McCulloch, Patricia	/42	Sharer, Lewis	/36
McElwee, Basil	/39	Skelton, Reba Mae	/46
McKee, Mary	/40	Slatton, John (Jay)	/80
McKinney, Joyce	/39	Stinson, Melanie	/60
Meeker, Mary Lou	/57	Sullivan, Anna	/45
Miller, Melanie	77	Taylor, Barbara	/49
Miller, Stella	/28	Taylor, Blake	/82
Morris, Estalene	/21	Temple, Reba (2 nd request)	32
Naseef, Dorothy	/45	Turner, Rondal	63
Noble, Janet	/45	Wanta, Steven R.	/56
Pellicone, Joseph	/34	Wiley, Elfreida	/58
Pelters, Paul	/45	Wilkinson, Krissy	70
Pierce, Ken (Larry)	/60	Williams, Earline	40
Pruitt, Elizabeth	/39	Young, Annette	/46
Ragland, JW	/41	Youree, Edna	/34
Richards, Kevin	/67	Ziegler, Adam (2 nd request)	/80
Robnett, Reba	/46		

I have enclosed authorizations for these patients; please provide us with complete copies of their medical and billing records from St. Thomas Hospital. Also enclosed are affidavits for the custodian of records to complete and execute, certifying each set of records. Please return these to me with the records.

If you need any additional information or documentation in order to provide us with these records, please let me know. Your assistance in this matter is greatly appreciated.

Sincerely,



Matthew H. Cline

MHC/nlw
Encls.

AUTHORIZATION FOR PRODUCTION OF MEDICAL DOCUMENTATION

Pursuant to TENNESSEE CODE ANNOTATED §29-26-122(a)(2)(E), I, John L. Alexander, Sr., have executed this HIPAA-compliant medical authorization that authorizes the Saint Thomas Outpatient Neurosurgical Center, LLC, and/or the designated legal representative for Saint Thomas Outpatient Neurosurgical Center, LLC, to obtain complete medical records regarding myself, John L. Alexander, Sr., Social Security Number 42-9620, and date of birth 1/1953.

The medical documentation which is authorized to be copied and produced to Saint Thomas Outpatient Neurosurgical Center, LLC, and/or the designated legal representative for Saint Thomas Outpatient Neurosurgical Center, LLC, would include, but not be limited to, medical records, medical reports, medical charts, X-ray reports or films, diagnostic studies, psychiatric records, psychological records, pharmacy or prescription medication records, pathology reports or slides, medical billing statements, and/or other documents, writings or tangible things related to the medical care and treatment of John L. Alexander, Sr.. The medical information that is authorized to be produced includes, but is not limited to, protected health information as defined at 45 C.F.R. 164.500, *et seq.*, (The HIPAA Privacy Rule).

I, John L. Alexander, Sr., understand that the information in the health records may include information which is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I, John L. Alexander, Sr., understand that I have the right to revoke this authorization at any time. I, John L. Alexander, Sr., understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department and/or employment human resources or personnel department. I, John L. Alexander, Sr., understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, or event or condition: June 28, 2020.

I, John L. Alexander, Sr., understand that authorizing the disclosure of this health information is voluntary and that I can refuse to sign this authorization. I, John L. Alexander, Sr., understand that I may inspect or copy the information to be used or disclosed, as provided by CFR 164.524. I, John L. Alexander, Sr., understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I, John L. Alexander, Sr., understand that the medical documentation and health information is being disclosed due to my claims for the severe injuries which I allege were caused when I was injected with contaminated drug products while I was under the care and treatment of Saint Thomas Outpatient Neurosurgical Center, LLC. The contaminated drug products were obtained by Saint Thomas Outpatient Neurosurgical Center, LLC from New England Compounding Pharmacy, LLC.

This health information may be disclosed to and may be used by the following organization:

Saint Thomas Outpatient Neurosurgical Center, LLC, and/or the designated legal representative for Saint Thomas Outpatient Neurosurgical Center, LLC
4230 Harding Road, Suite 901
Nashville, TN 37205
Telephone # (615) 341-3425

John L. Alexander, Sr.
John L. Alexander, Sr.

Date: 6/28/13

LIMITED AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION OR RECORDS

By signing below, I hereby request and authorize the Health Care Provider identified below to disclose certain information (the "Information") as provided in this Authorization.

Information To Be Used Or Disclosed

Patient Name: Ann Bequette Patient Identifier: DOB: -1943

Description of Information: Any and all medical information and records, or true and correct copies thereof, in your possession, custody or control, including, but not limited to, medical histories, records, reports, summaries, diagnosis, prognoses, records of treatment and medication ordered and/or given, entries, letters or correspondence to other physicians, electrocardiograms, x-ray films and reports, ultrasounds, diagnostic imaging studies; laboratory data and records, pathological reports, slides and specimens, prescription records, insurance records, bills or statements of account, incident reports, birth certificates, death certificates and all other written or graphic data prepared, kept, made or maintained in your possession, custody or control and summaries of injuries, treatment and prognosis, if requested, that pertain to the Patient. THIS AUTHORIZATION DOES NOT AUTHORIZE VERBAL COMMUNICATIONS WITH THE REFERENCED INDIVIDUAL OR ORGANIZATION.

Persons Or Organizations Authorized To Disclose The Information

Health Care Provider: Saint Thomas Outpatient Neurosurgical Center, LLC; Howell Allen Clinic A Professional Corporation; St. Thomas Hospital; John Weeks Culclasure, M.D.; Debra V. Schamberg, R.N.

I authorize the Health Care Provider(s) and its employees and agents to disclose the Information as provided in this Authorization. A photostatic copy of this Authorization is to be considered as effective as the original. I understand that I am not required to sign this Authorization. The Health Care Provider will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization.

Persons or Organizations Authorized to Receive the Information

Howell Allen Clinic A Professional Corporation or any representative, attorney or investigator from said organization, c/o Gregory B. Lanford, M.D., 2011 Murphy Ave, Ste 301, Nashville, TN 37203-2023.

Purpose of the Requested Use or Disclosure

At the request of the individual

Expiration and Revocation of This Authorization

Expiration Date or Event: 12/18/13

I understand that I may revoke this Authorization at any time prior to the expiration date or event, but that my revocation will not have any affect on actions taken by the Health Care Provider, its employees or agents before they received my revocation. Should I desire to revoke this Authorization, I must send written notice to the Health Care Provider at the following address:

I understand that I may see and copy the Information if I ask for it. I understand that any Information released may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy law or regulations.

Ann Bequette 5/18/13
Signature (Patient) Date

Signature (Authorized Representative) Date

Signature (Witness)

Relationship to Patient

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: <i>Travis Besaw</i>	Birth Date: 52	Social Security No. (optional): -9369
Provider's/Health Plan's Name:	Recipient's Name:	
Provider's/Health Plan's Address:	Address 1:	
	Address 2:	
	City:	State:
		Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: April 1, 2014

Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
<input checked="" type="checkbox"/> All PHI in medical record <input type="checkbox"/> Admission form <input type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input type="checkbox"/> Medication Sheets		<input type="checkbox"/> Operative Information <input type="checkbox"/> Cath lab <input type="checkbox"/> Special test/therapy <input type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input type="checkbox"/> Transfer forms <input type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input type="checkbox"/> Itemized bill: <input type="checkbox"/> UB-92: <input type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. *TB* (Initial) If not applicable, check here.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redislosed.
5. I understand that my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. **THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS.** You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: <i>Ira and Karen</i>	Date: 5/17/13
Print Name of Patient/Plan Member's Representative: <i>Robert Young</i>	Relationship to Patient/Plan Member: <i>Attorney</i>

Revised 3/2003

LIMITED AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION OR RECORDS

By signing below, I hereby request and authorize the Health Care Provider identified below to disclose certain information (the "Information") as provided in this Authorization.

Information To Be Used Or Disclosed

Patient Name: Carolyn E. Bland Patient Identifier: DOB: 1-1946

Description of Information: Any and all medical information and records, or true and correct copies thereof, in your possession, custody or control, including, but not limited to, medical histories, records, reports, summaries, diagnosis, prognoses, records of treatment and medication ordered and/or given, entries, letters or correspondence to other physicians, electrocardiograms, x-ray films and reports, ultrasounds, diagnostic imaging studies, laboratory data and records, pathological reports, slides and specimens, prescription records, insurance records, bills or statements of account, incident reports, birth certificates, death certificates and all other written or graphic data prepared, kept, made or maintained in your possession, custody or control and summaries of injuries, treatment and prognosis, if requested, that pertain to the Patient. THIS AUTHORIZATION DOES NOT AUTHORIZE VERBAL COMMUNICATIONS WITH THE REFERENCED INDIVIDUAL OR ORGANIZATION.

Persons Or Organizations Authorized To Disclose The Information

Health Care Provider: Saint Thomas Outpatient Neurosurgical Center, LLC; Howell Allen Clinic A Professional Corporation; John Weeks Culclasure, M.D.; Debra V. Schamberg, R.N.

I authorize the Health Care Provider(s) and its employees and agents to disclose the Information as provided in this Authorization. A photostatic copy of this Authorization is to be considered as effective as the original. I understand that I am not required to sign this Authorization. The Health Care Provider will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization.

Persons or Organizations Authorized to Receive the Information

Saint Thomas Outpatient Neurosurgical Center, LLC or any representative, attorney or investigator from said organization, c/o Gregory B. Lanford, M.D., 2011 Murphy Ave, Ste 301, Nashville, TN 37203-2023 or Floor 9, 4230 Harding Pike, Nashville, TN 37205-2013.

Purpose of the Requested Use or Disclosure

Legal

Expiration and Revocation of This Authorization

Expiration Date or Event: 10-3-2013

I understand that I may revoke this Authorization at any time prior to the expiration date or event, but that my revocation will not have any affect on actions taken by the Health Care Provider, its employees or agents before they received my revocation. Should I desire to revoke this Authorization, I must send written notice to the Health Care Provider at the following address:

I understand that I may see and copy the Information if I ask for it. I understand that any Information released may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy law or regulations.

Carolyn E. Bland 04-03-13
Signature (Patient) Date

Signature (Authorized Representative) Date

Signature (Witness)

Relationship to Patient

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: <i>Ben Batchel</i>	Birth Date: 78	Social Security No. (optional): -9540
Provider's/Health Plan's Name:	Recipient's Name:	
Provider's/Health Plan's Address:	Address 1: F	Address 2:
	City:	State:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: April 1, 2014

Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
<input type="checkbox"/> All PHI in medical record <input type="checkbox"/> Admission form <input type="checkbox"/> Dictation reports <input type="checkbox"/> Physician orders <input type="checkbox"/> Intake/outtake <input type="checkbox"/> Clinical Test <input type="checkbox"/> Medication Sheets		<input type="checkbox"/> Operative Information <input type="checkbox"/> Cath lab <input type="checkbox"/> Special test/therapy <input type="checkbox"/> Rhythm Strips <input type="checkbox"/> Nursing Information <input type="checkbox"/> Transfer forms <input type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input type="checkbox"/> Itemized bill: <input type="checkbox"/> UB-92: <input type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. *BG.B* (Initial) If not applicable, check here.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be rediscovered.
5. I understand that my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

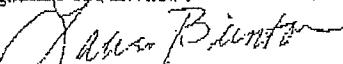
The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. **THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS.** You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:
*Benjamin G. Batchel*Date:
*5-20-13*Print Name of Patient/Plan Member's Representative:
*Robert Young*Relationship to Patient/Plan Member:
Honey

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations					
Patient/Plan Member Name: Laura Brinton		Birth Date:	63	Social Security No.:	1-2028
Persons or Organizations Authorized to Disclose the Information: St. Thomas Hospital Saint Thomas Network Saint Thomas Health Saint Thomas Medical Clinic		Persons or Organizations Authorized to Receive the Information: Saint Thomas Outpatient Neurosurgical Center, LLC			
This authorization will expire on the following: (Fill in the Date or the Event but not both.) Date: 04/20/14 Event:					
Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121					
Description of information to be used or disclosed					
Is this request for psychotherapy notes? <input type="checkbox"/> Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. <input type="checkbox"/> No, then you may check as many items below as you need.					
Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input type="checkbox"/> Itemized bill: <input type="checkbox"/> UB-92: <input type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	
I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. <input checked="" type="checkbox"/> (Initial) If not applicable, check here. <input type="checkbox"/>					
I understand that: 1. I may refuse to sign this authorization and that it is strictly voluntary. 2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that my attorney will receive copies of all records received through this authorization. 6. I, through my attorney, will get a copy of this form after I sign it. 7. A photostatic copy of this Authorization is to be considered as effective as the original.					
Section B:					
THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard, KINNARD, CLAYTON & BEVERIDGE, 127 Woodmont Boulevard, Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.					
Section C: Signatures					
I have read the above and authorize the disclosure of the protected health information as stated.					
Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: 				Date: 3/25/13	
Print Name of Patient/Plan Member's Representative: Laura Brinton		Relationship to Patient/Plan Member: Self			

**AUTHORIZATION FOR USE OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION**

Patient Name: Denis Brock DOB: 12/12/1947 Social Security Number: 123-45-7255

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: <u>Denis S. Brock</u>	Date: <u>7-25-13</u>
Print Name of Patient/Plan Member's Representative: <u>Denis S. Brock</u>	Relationship to Patient/Plan Member: <u>Self</u>

AUTHORIZATION FOR USE OR DISCLOSURE OF

PROTECTED HEALTH INFORMATION

Patient Name: Margaret Rhea BryantSocial Security Number: 1-7413Date of Birth: 1938Phone Number: 931.668.4722

1. I authorize Saint Thomas Health Services, Saint Thomas Outpatient Neurosurgical Center, LLC, St. Thomas Hospital, St. Thomas Hospitalist Group, St. Thomas Neurology Group, PLC to disclose my health information to:

Galligan & Newman, 309 W. Main Street, McMinnville, TN 37110, Christina S. Sadlow, M.D., Damon M. Abaray, M.D., E. Berry Holt, III, Gregory B. Lanford, M.D., Heritage Medical Associates, P.C., Howell Allen Clinic, John R. Voigt, Esq., Joseph R. Zenisek, M.D., Steven A. Embry, M.D., Subir Prasad, M.D., Vanderbilt University Medical Center

The purpose(s) for the use or disclose is as follows: Litigation.

2. The type and amount of information to be used or disclosed is as follows:

Health information covering treatment from July 1, 2012 to September 18, 2012.

<input type="checkbox"/> Abstract (includes H&P, Progress Notes, Procedure Notes, Procedure Reports, etc.)	<input type="checkbox"/> Summary
<input type="checkbox"/> Copy of Medical Records only	<input type="checkbox"/> Discharge Summary (DS)
<input type="checkbox"/> Copy of Complete Records (Medical & Financial)	<input type="checkbox"/> Operative/Procedure Report(OP)
<input type="checkbox"/> History and Physical (H&P)	<input type="checkbox"/> Pathology Report
<input type="checkbox"/> Consultation	<input type="checkbox"/> Laboratory Report

Other:

3. I understand that my health information may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for drug and alcohol abuse.

4. I understand that I have a right to revoke this authorization at any time. I understand that, if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management department. I understand that my revocation will not apply to the extent that the above named provider has taken action in reliance on this authorization. I understand that my revocation will not apply if this authorization was obtained as a condition of obtaining insurance coverage and the law provides my insurer with the right to contest a claim under my policy or the policy itself. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____.

5. If I fail to specify an expiration date, event, or condition, this authorization will expire in six months. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. The doctor or hospital may not condition treatment, payment, enrollment in its health plan, or eligibility for benefits on my signing this authorization. I understand that if I authorize the above named provider to disclose my health information, the health information may be subject to redisclosure by the recipient and may no longer be protected by certain federal privacy regulations. If I have any questions about disclosure of my health information I can contact the provider listed above.

Margaret Rhea Bryant
Signature of Patient or Legal Representative

Oct. 5, 2012
Date

If signed by Legal Representative, Relationship to Patient

AUTHORIZATION FOR USE OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION

Patient Name: Ronda Burns Social Security Number: xxx-xx-5327
 Date of Birth: 4-62 Phone Number: 615-452-1383

I authorize: John W. Culclasure, M.D.
Timothy Schoettle, M.D.
Saint Thomas Outpatient Neurosurgical Center, LLC
St. Thomas Hospital
Saint Thomas Health Services

to disclose my information to: Howell Allen Clinic

The purpose(s) for the use or disclose is as follows: Litigation

The type and amount of information to be used or disclosed is as follows:

Health information covering treatment from August 1, 2012 to August 1, 2013

<input type="checkbox"/> Abstract (includes H&P, Progress Notes, Procedure Notes, Procedure Reports, etc.)	<input type="checkbox"/> Summary
<input type="checkbox"/> Copy of Medical Records only	<input type="checkbox"/> Discharge Summary (DS)
<input checked="" type="checkbox"/> Copy of Complete Records (Medical & Financial)	<input type="checkbox"/> Operative/Procedure Report(OP)
<input type="checkbox"/> History and Physical (H&P)	<input type="checkbox"/> Pathology Report
<input type="checkbox"/> Consultation	<input type="checkbox"/> Laboratory Report
Other:	

I understand that my health information may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for drug and alcohol abuse.

I understand that I have a right to revoke this authorization at any time. I understand that, if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management department. I understand that my revocation will not apply to the extent that the above named provider has taken action in reliance on this authorization. I understand that my revocation will not apply if this authorization was obtained as a condition of obtaining insurance coverage and the law provides my insurer with the right to contest a claim under my policy or the policy itself. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. The doctor or hospital may not condition treatment, payment, enrollment in its health plan, or eligibility for benefits on my signing this authorization. I understand that if I authorize the above named provider to disclose my health information, the health information may be subject to redisclosure by the recipient and may no longer be protected by certain federal privacy regulations. If I have any questions about disclosure of my health information I can contact the provider listed above.

Ronda Burns

Signature of Patient or Legal Representative

4-16-13

Date

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: <i>Barbara Campbell</i>	Birth Date: /54	Social Security No. (optional): -32,80	
Provider's/Health Plan's Name:	Recipient's Name:		
Provider's/Health Plan's Address:	Address 1: Address 2: City: _____ State: _____ Zip: _____		

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: April 1, 2014 Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s)
<input type="checkbox"/> All PHI in medical record <input type="checkbox"/> Admission form <input type="checkbox"/> Dictation reports <input type="checkbox"/> Physician orders <input type="checkbox"/> Intake/outtake <input type="checkbox"/> Clinical Test <input type="checkbox"/> Medication Sheets		<input type="checkbox"/> Operative Information <input type="checkbox"/> Cath lab <input type="checkbox"/> Special test/therapy <input type="checkbox"/> Rhythm Strips <input type="checkbox"/> Nursing Information <input type="checkbox"/> Transfer forms <input type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input type="checkbox"/> Itemized bill: <input type="checkbox"/> UB-92: <input type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. BC (Initial) If not applicable, check here.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be rediscovered.
5. I understand that my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. **THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS.** You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Plan Member Representative:

Barbara Campbell

Date:

5/19/13

Print Name of Patient/Plan Member's Representative:

Barbara Campbell

Relationship to Patient/Plan Member:

Attorney

Revised 3/2003

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations					
Patient/Plan Member Name: CINDY A. CARMAN		Birth Date: 1971		Social Security No. (optional): 2889	
Provider's/Health Plan's Name: ST. THOMAS HOSPITAL		Recipient's Name: SAINT THOMAS OUTPATIENT NEUROSURGICAL CENTER LLC Through Principal Place of Business			
Provider's/Health Plan's Address: E. Berry Holt, III Ste 800 102 Woodmont Blvd., Nashville, TN 37205-2221		Address 1: FL9			
		Address 2: 4230 HARDING PKW			
		City: NASHVILLE		State: TN	Zip: 37205-2013
This authorization will expire on the following: (Fill in the Date or the Event but not both.)					
Date: Event: DISMISSAL OF LITIGATION					
Purpose of Disclosure: Legal Description of information to be used or disclosed					
Is this request for psychotherapy notes? <input type="checkbox"/> Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. <input type="checkbox"/> No, then you may check as many items below as you need.					
Description: ALL	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> ALL PHI in medical record		<input type="checkbox"/> Operative Information		<input type="checkbox"/> Labor/delivery sum.	
<input type="checkbox"/> Admission form		<input type="checkbox"/> Cath lab		<input type="checkbox"/> OB nursing assess	
<input type="checkbox"/> Dictation reports		<input type="checkbox"/> Special test/therapy		<input type="checkbox"/> Postpartum flow sheet	
<input type="checkbox"/> Physician orders		<input type="checkbox"/> Rhythm strips		<input checked="" type="checkbox"/> Itemized bill:	
<input type="checkbox"/> Intake/outtake		<input type="checkbox"/> Nursing information		<input type="checkbox"/> UB-92:	
<input type="checkbox"/> Clinical test		<input type="checkbox"/> Transfer forms		<input type="checkbox"/> Other:	
<input type="checkbox"/> Medication sheets		<input type="checkbox"/> ER information		<input type="checkbox"/> Other:	
I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. (Initial) If not applicable, check here. <input type="checkbox"/>					
I understand that:					
<ol style="list-style-type: none"> I may refuse to sign this authorization and that it is strictly voluntary. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be rediscovered. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I get a copy of this form after I sign it. 					
Section B: Is the request for PHI for the purpose of marketing? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
If yes, the health plan or health care provider must complete Section B; otherwise skip to Section C.					
Will the recipient receive financial or in-kind compensation for using or disclosing this information?				<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
If yes, describe:					
Section C: Signature section					
I have read the above and authorize the disclosure of the protected health information as stated.					
Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: <i>Cindy A. Carman</i>				Date: x 7-2-13	
Print Name of Patient/Plan Member's Representative: CINDY A. CARMAN				Relationship to Patient/Plan Member:	

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: <i>Teresa Carroll</i>	Birth Date: 149	Social Security No. (optional): -95608
Provider's/Health Plan's Name:	Recipient's Name:	
Provider's/Health Plan's Address:	Address 1:	
	Address 2:	
	City:	State:
		Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: April 1, 2014

Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
<input checked="" type="checkbox"/> All PHI in medical record <input type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input checked="" type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. *TC* (Initial) If not applicable, check here.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. **THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS.** You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: <i>Teresa Carroll</i>	Date: 5/19/13
Print Name of Patient/Plan Member's Representative: <i>Teresa Ann Carroll Robert Haeng</i>	Relationship to Patient/Plan Member: <i>Attorney</i>

Revised 3/2003

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: <u>Kathy J. Chambers</u>	Birth Date: <u>35/05/51</u>	Social Security No.: <u>415-88-9081</u>
Persons or Organizations Authorized to Disclose the Information: Howell Allen Clinic a Professional Corporation	Persons or Organizations Authorized to Receive the Information: Saint Thomas Outpatient Neurosurgical Center, LLC	

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: 04/20/14

Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-12

Description of information to be used or disclosed

Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. KJ (Initial) If not applicable, check here.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: <u>Kathy Chambers</u>	Date: <u>4-22-2013</u>
Print/Name of Patient/Plan Member's Representative: <u>Kathy J. Chambers</u>	Relationship to Patient/Plan Member: <u>Self</u>

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations.

Patient/Plan Member Name: <i>Billy Joe Coleman</i>	Birth Date: 159	Social Security No. (optional): 13273	
Provider's/Health Plan's Name:	Recipient's Name:		
Provider's/Health Plan's Address:	Address 1:		
	Address 2:		
	City:	State:	Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: April 1, 2014

Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s)
<input checked="" type="checkbox"/> All PHI in medical record <input type="checkbox"/> Admission form <input type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input type="checkbox"/> Transfer forms <input type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input type="checkbox"/> Itemized bill: <input type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other; all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. *SAC* (Initial) If not applicable, check here.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. **THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS.** You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel (attorney and address), within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:

Billy Joe Coleman

Date:

5/20/13

Print Name of Patient/Plan Member's Representative:

Robert Young

Relationship to Patient/Plan Member:

Attorney

Revised 3/2003

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: Thomas Randy Davis	Birth Date: , 1946	Social Security No. -2523
Provider's/Health Plan's Name: ST. THOMAS HOSPITAL	Recipient's Name: SAINT THOMAS OUTPATIENT NEUROSURGICAL CENTER, LLC	
Provider's/Health Plan's Address: E. Berry Holt, III STE 800 102 Woodmont Blvd Nashville, TN 37205-2221	Through: Principal Place of Business Address FL 9 4230 Harding Pike Nashville, TN 37205-2013	

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: Event: **DISMISSAL OF LITIGATION**

Purpose of Disclosure: Legal	Description of information to be used or disclosed				
Is this request for psychotherapy notes? <input type="checkbox"/> Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. <input type="checkbox"/> No, then you may check as many items below as you need.					
Description: ALL	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> ALL PHI in medical record		<input type="checkbox"/> Operative Information		<input type="checkbox"/> Labor/delivery sum.	
<input type="checkbox"/> Admission form		<input type="checkbox"/> Cath lab		<input type="checkbox"/> OB nursing assess	
<input type="checkbox"/> Dictation reports		<input type="checkbox"/> Special test/therapy		<input type="checkbox"/> Postpartum flow sheet	
<input type="checkbox"/> Physician orders		<input type="checkbox"/> Rhythm strips		<input checked="" type="checkbox"/> Itemized bill:	
<input type="checkbox"/> Intake/outtake		<input type="checkbox"/> Nursing information		<input type="checkbox"/> UB-92:	
<input type="checkbox"/> Clinical test		<input type="checkbox"/> Transfer forms		<input type="checkbox"/> Other:	
<input type="checkbox"/> Medication sheets		<input type="checkbox"/> ER information		<input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. (Initial) If not applicable, check here.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be rediscovered.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing?

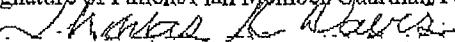
If yes, the health plan or health care provider must complete Section B; otherwise, skip to Section C.

Will the recipient receive financial or in-kind compensation for using or disclosing this information? Yes No
If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:



Date:

7/2/13

Print Name of Patient/Plan Member's Representative: Thomas Randy Davis	Relationship to Patient/Plan Member:
--	--------------------------------------

Apr. 16, 2013 3:42PM

No. 1885 P. 5

AUTHORIZATION FOR USE OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION

Patient Name: Jerry Demps Social Security Number: xxx-xx-1190
 Date of Birth: -56 Phone Number: 931-510-9225

I authorize: John W. Culclasure, M.D.
Scott Standard, M.D.
Howell Allen Clinic, A Professional Corporation
St. Thomas Hospital
Saint Thomas Health Services

to disclose my information to: Saint Thomas Outpatient Neurosurgical Center, LLC

The purpose(s) for the use or disclose is as follows: Litigation

The type and amount of information to be used or disclosed is as follows:

Health information covering treatment from June 1, 2012 to June 1, 2013

<input type="checkbox"/> Abstract (includes H&P, Progress Notes, Procedure Notes, Procedure Reports, etc.)	<input type="checkbox"/> Summary
<input checked="" type="checkbox"/> Copy of Medical Records only	<input type="checkbox"/> Discharge Summary (DS)
<input checked="" type="checkbox"/> Copy of Complete Records (Medical & Financial)	<input type="checkbox"/> Operative/Procedure Report(OP)
<input type="checkbox"/> History and Physical (H&P)	<input type="checkbox"/> Pathology Report
<input type="checkbox"/> Consultation	<input type="checkbox"/> Laboratory Report
Other:	

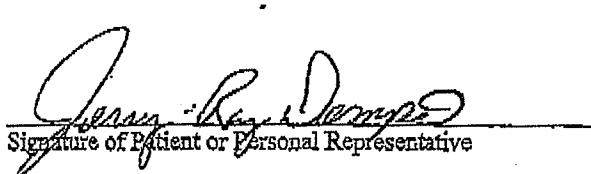
I understand that my health information may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for drug and alcohol abuse.

I understand that I have a right to revoke this authorization at any time. I understand that, if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management department. I understand that my revocation will not apply to the extent that the above named provider has taken action in reliance on this authorization. I understand that my revocation will not apply if this authorization was obtained as a condition of obtaining insurance coverage and the law provides my insurer with the right to contest a claim under my policy or the policy itself. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. The doctor or hospital may not condition treatment, payment, enrollment in its health plan, or eligibility for benefits on my signing this authorization. I understand that if I authorize the above named provider to disclose my health information, the health information may be subject to redisclosure by the recipient and may no longer be protected by certain federal privacy regulations. If I have any questions about disclosure of my health information I can contact the provider listed above.

4-15-13

Date



Jerry R. Demps
Signature of Patient or Personal Representative

AUTHORIZATION FOR RECEIVE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: Sue Eggleston	Birth Date: 1/62	Social Security No.: -0343
Persons or Organizations Authorized to Disclose the Information: St. Thomas Hospital Saint Thomas Network Saint Thomas Health Saint Thomas Medical Clinic	Persons or Organizations Authorized to Receive the Information: Saint Thomas Outpatient Neurosurgical Center, LLC	

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: 04/20/14

Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s)
X All PHI in medical record X Admission form X Dictation reports X Physician orders X Intake/outtake X Clinical Test X Medication Sheets		X Operative Information X Cath lab X Special test/therapy X Rhythm Strips X Nursing Information X Transfer forms X ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet X Itemized bill: X UB-92: X Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. S.E. (Initial) If not applicable, check here.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:

Sue Eggleston

Date:

3-25-13

Print Name of Patient/Plan Member's Representative:

Sue Eggleston

Relationship to Patient/Plan Member:

Self

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: <i>Danny Evans</i>	Birth Date <i>164</i>	Social Security No. (optional): <i>-1823</i>	
Provider's/Health Plan's Name:	Recipient's Name:		
Provider's/Health Plan's Address:	Address 1:		
	Address 2:		
	City: <i></i>	State: <i></i>	Zip: <i></i>

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: April 1, 2014

Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s)
<input checked="" type="checkbox"/> All PHI in medical record <input type="checkbox"/> Admission form <input type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input type="checkbox"/> Medication Sheets		<input type="checkbox"/> Operative Information <input type="checkbox"/> Cath lab <input type="checkbox"/> Special test/therapy <input type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input type="checkbox"/> Transfer forms <input type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input checked="" type="checkbox"/> Postpartum flow sheet <input type="checkbox"/> Itemized bill: <input type="checkbox"/> UB-92: <input type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. D.E. (Initial) If not applicable, check here.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be rediscovered.
5. I understand that my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. **THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS.** You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:
*Danny Evans*Date:
*5/22/13*Print Name of Patient/Plan Member's Representative:
*Robert Young*Relationship to Patient/Plan Member:
Attorney

Revised 3/2003

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: Rosemary C. Ferguson	Birth Date: 1/1956	Social Security No. (optional):	
Provider's/Health Plan's Name: St. Thomas Hospital	Recipient's Name:		
Provider's/Health Plan's Address: 4220 Harding Road Nashville, TN 37205	Address 1:		
	Address 2:		
City:		State:	Zip:

This authorization will expire on the following: (Fill in the Date of the Event but not both.)

Date: April 1, 2014

Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s)
<input checked="" type="checkbox"/> All PHI in medical record <input type="checkbox"/> Admission form <input type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input type="checkbox"/> Special test/therapy <input type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input type="checkbox"/> Itemized bill: <input type="checkbox"/> UB-92: <input type="checkbox"/> Other, all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. (Initial) If not applicable, check here.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. **THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS.** You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:

Rosemary C. Ferguson

Date:

Print Name of Patient/Plan Member's Representative:

Robert Young

Relationship to Patient/Plan Member:

Attorney

Revised 3/2003

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (optional):	
Ellen Glatman	1960		
Provider's/Health Plan's Name:	Recipient's Name:		
St. Thomas Hospital			
Provider's/Health Plan's Address:	Address 1:		
4220 Harding Road Nashville, TN 37205	Address 2:		
	City:	State:	Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: April 1, 2014 Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input type="checkbox"/> Cath Lab <input type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input checked="" type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. (Initial) If not applicable, check here.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. **THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS.** You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:

Date:

Print Name of Patient/Plan Member's Representative:

Robert Young

Relationship to Patient/Plan Member:

Attorney

Revised 3/2003

LIMITED AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

The purpose of this Authorization is to comply with the requirements of T.C.A. 29-26-121, and allows persons or entities listed in a T.C.A 29-26-121 Notice Letter to obtain copies of Shirley Higdon's (hereinafter referred to as "Patient") medical records.

This Authorization allows you to provide a copy of Patient's medical records to the persons or entities listed in the attached Notice letter. Patient further requests that you provide a copy of those same records to Patient's attorneys, Evans Petree PC at the time you provide copies of the record pursuant to this Authorization.

THIS AUTHORIZATION DOES NOT ALLOW YOU TO DISCUSS PATIENT, OR PATIENT'S MEDICAL RECORDS WITH ANY OTHER HEALTH CARE PROVIDER, OR ATTORNEY.

PATIENT SPECIFICALLY MAINTAINS THE RIGHTS OF CONFIDENTIALITY PROVIDED BY ALL APPLICABLE STATE AND FEDERAL LAW.

Revocation: This Authorization may be revoked in writing, at any time, except where it has already been used and relied on it to make a use or disclosure. Written revocation will become effective once it is processed and received. Consequences of Signing this Form: Please be aware that re-disclosure may lead to the loss of protected status.

PATIENT'S FULL NAME: Shirley Higdon

ADDRESS: 931 Jeanette Holladay Road, Parsons, Tennessee 38363
DOB: /1938 SSN: 5655

I authorize the persons listed on the attached notice provider list to use and disclose to THE PERSONS NAMED IN THE ATTACHED PROVIDER NOTICE LETTER the complete medical record of the patient identified above. The purpose or need for the information is to comply with T.C.A. 29-26-121. Patient further requests that you provide an exact copy of the same records to Plaintiff's Attorneys, Evans Petree PC at the time you provide copies of the record pursuant to this Authorization.

Expiration: This Authorization expires on the date you specify below or six months from the date signed, whichever is earlier. Once this Authorization expires, we will no longer use and disclose your health information for the described purposes unless you sign a new Authorization Form.

This Authorization expires: ✓ in six (6) months; or on the following date: _____

Shirley Higdon
Signature of Patient or Personal Representative

Shirley Higdon
Printed Name of Patient

Date: 2/18/2013

*If Personal Representative, the Patient is unable to sign because of: Minor; Incompetent; Deceased; Other (Explain: _____)

Feb. 25, 2013 8:01AM

No. 01241

42/21/13

Qm



J. STEPHEN KING
JKING@EVANSPETREE.COM

DIRECT FAX 901.374.7548

February 15, 2013

CERTIFIED MAIL
RETURN RECEIPT REQUESTED

St. Thomas Outpatient Neurosurgical Center
Debra Schamberg
4230 Harding Road, Suite 901
Nashville, TN 37205

RE: Notice of Claim for Medical Malpractice
Shirley R. Higdon
DOB: 1/1938
MRN#: SC24325

Gentlemen:

Please be advised that this office represents Shirley R. Higdon whose date of birth is 1938. Mrs. Higdon is the patient whose treatment is the subject of this notice and claim.

I am the attorney representing Shirley R. Higdon. My name and address are:

J. Stephen King
Evans | Petree PC
1000 Ridgeway Loop Road, Suite 200
Memphis, Tennessee 38120

The name and address of all healthcare providers against whom this claim is being made and to whom notice is being provided are as follows:

Name	Current Business Address	Dept. of Health website address
St. Thomas Outpatient Neurosurgical Center	4230 Harding Road, Suite 901 Nashville, TN 37205	Debra Schamberg 4230 Harding Road, Suite 901 Nashville, TN 37205
Howell Allen Clinic	2011 Murphy Avenue Suite 301 Nashville, TN 37203	

Feb. 25, 2013 8:01AM

No. 0124 P. 5

EP

Page 2

	Attn: Gregory B. Lunford, M.D., Registered Agent	
Saint Thomas Network	4220 Harding Pike Nashville, TN Attn: Dawn Rudolph	102 Woodmont Blvd. Suite 800 Nashville, TN 37205 Attn: E. Berry Holt III
Saint Thomas Health	102 Woodmont Blvd. Suite 800 Nashville, TN 37205 Attn: E. Berry Holt III	
Saint Thomas Hospital	4220 Harding Pike Nashville, TN Attn: Dawn Rudolph	102 Woodmont Blvd. Suite 800 Nashville, TN 37205 Attn: Dawn Rudolph

Enclosed is a HIPAA client medical authorization signed by Mrs. Higdon permitting you to obtain complete medical records from each healthcare provider being sent this notice.

Sincerely,



James Stephen King

JSK/lrs
Enclosure
cc: Mrs. Shirley R. Higdon

Gregory B. Lunford, M.D.
2011 Murphy Avenue
Suite 301
Nashville, TN 37203-2023

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: Joanne L. Hill	Birth Date: 3/4/7	Social Security No.: 439-08
Persons or Organizations Authorized to Disclose the Information: St. Thomas Hospital Saint Thomas Network Saint Thomas Health Saint Thomas Medical Clinic	Persons or Organizations Authorized to Receive the Information: Saint Thomas Outpatient Neurosurgical Center, LLC	

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: 04/20/14

Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> X Cath lab <input checked="" type="checkbox"/> X Special test/therapy <input checked="" type="checkbox"/> X Rhythm Strips <input checked="" type="checkbox"/> X Nursing Information <input checked="" type="checkbox"/> X Transfer forms <input checked="" type="checkbox"/> X ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> X Itemized bill: <input checked="" type="checkbox"/> X UB-92: <input checked="" type="checkbox"/> X Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. (Initial) If not applicable, check here.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:

Date:

Print Name of Patient/Plan Member's Representative:

Joanne L. Hill

Relationship to Patient/Plan Member:

Self

LIMITED AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION OR RECORDS

By signing below, I hereby request and authorize the Health Care Provider identified below to disclose certain information (the "Information") as provided in this Authorization.

Information To Be Used Or Disclosed

Patient Name: Glenda J. Hurt Patient Identifier: DOB: -1949

Description of Information: Any and all medical information and records, or true and correct copies thereof, in your possession, custody or control, including, but not limited to, medical histories, records, reports, summaries, diagnosis, prognoses, records of treatment and medication ordered and/or given, entries, letters or correspondence to other physicians, electrocardiograms, x-ray films and reports, ultrasounds, diagnostic imaging studies, laboratory data and records, pathological reports, slides and specimens, prescription records, insurance records, bills or statements of account, incident reports, birth certificates, death certificates and all other written or graphic data prepared, kept, made or maintained in your possession, custody or control and summaries of injuries, treatment and prognosis, if requested, that pertain to the Patient. THIS AUTHORIZATION DOES NOT AUTHORIZE VERBAL COMMUNICATIONS WITH THE REFERENCED INDIVIDUAL OR ORGANIZATION.

Persons Or Organizations Authorized To Disclose The Information

Health Care Provider: Saint Thomas Outpatient Neurosurgical Center, LLC; Howell Allen Clinic A Professional Corporation; St. Thomas Hospital; John Weeks Culclasure, M.D.; Debra V. Schamberg, R.N.; Saint Thomas Network; Saint Thomas Health; Patricia G. Beckham

I authorize the Health Care Provider(s) and its employees and agents to disclose the Information as provided in this Authorization. A photostatic copy of this Authorization is to be considered as effective as the original. I understand that I am not required to sign this Authorization. The Health Care Provider will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization.

Persons or Organizations Authorized to Receive the Information

Howell Allen Clinic A Professional Corporation or any representative, attorney or investigator from said organization, c/o Gregory B. Lanford, M.D., 2011 Murphy Ave, Ste 301, Nashville, TN 37203-2023.

Purpose of the Requested Use or Disclosure

At the request of the individual

Expiration and Revocation of This Authorization

Expiration Date or Event: 6/14/14

I understand that I may revoke this Authorization at any time prior to the expiration date or event, but that my revocation will not have any affect on actions taken by the Health Care Provider, its employees or agents before they received my revocation. Should I desire to revoke this Authorization, I must send written notice to the Health Care Provider at the following address:

I understand that I may see and copy the Information if I ask for it. I understand that any Information released may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy law or regulations.

Glenda J. Hurt 6/14/13
Signature (Patient) Date

Signature (Authorized Representative) Date

Stephanie Petley

Relationship to Patient

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient/Plan Member Name: William E. Johnson, Sr.		Date of Birth: 62	Social Security No.: 0664
Persons or Organizations Authorized to Disclose the Information: St. Thomas Hospital Saint Thomas Network Saint Thomas Health Saint Thomas Medical Clinic		Persons or Organizations Authorized to Receive the Information: Saint Thomas Outpatient Neurosurgical Center, LLC	

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: 04/20/14

Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-131

Description of information to be used or disclosed

Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> X Cath lab <input checked="" type="checkbox"/> X Special test/therapy <input checked="" type="checkbox"/> X Rhythm Strips <input checked="" type="checkbox"/> X Nursing Information <input checked="" type="checkbox"/> X Transfer forms <input checked="" type="checkbox"/> X EKG Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> <input checked="" type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill <input checked="" type="checkbox"/> UB-92 <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. (Initial) If not applicable, check here.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: <i>William E. Johnson, Sr.</i>	Date: 3-21-13
Print Name of Patient/Plan Member's Representative: William E. Johnson, Sr.	Relationship to Patient/Plan Member: Self

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name:	Birth Date:	Social Security No. (optional):	
Dorris Jordan	/1957		
Provider's/Health Plan's Name:	Recipient's Name:		
St. Thomas Hospital			
Provider's/Health Plan's Address:	Address 1:		
	Address 2:		
	4220 Harding Road Nashville, TN 37205	City:	State:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: April 1, 2014

Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input checked="" type="checkbox"/> Labor/delivery sum. <input checked="" type="checkbox"/> OB nursing assess <input checked="" type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input checked="" type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. (Initial) If not applicable, check here.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

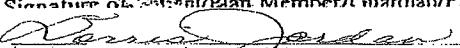
Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. **THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS.** You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

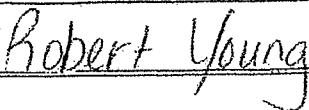
I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:

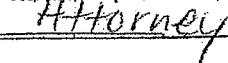


Date:

Print Name of Patient/Plan Member's Representative:



Relationship to Patient/Plan Member:



Revised 3/2003

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: John Kinsey	Birth Date: 1962	Social Security No. (optional):	
Provider's/Health Plan's Name: St. Thomas Hospital	Recipient's Name:		
Provider's/Health Plan's Address: 4220 Harding Road Nashville, TN 37205	Address 1:		
	Address 2:		
	City:	State:	Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: April 1, 2014

Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input type="checkbox"/> Admission form <input type="checkbox"/> Dictation reports <input type="checkbox"/> Physician orders <input type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input type="checkbox"/> Cath Lab <input type="checkbox"/> Special test/therapy <input type="checkbox"/> Rhythm Strips <input type="checkbox"/> Nursing Information <input type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input checked="" type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB/nursing assess <input type="checkbox"/> Postpartum flow sheet <input type="checkbox"/> Itemized bill: <input type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other, all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. (Initial) If not applicable, check here.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. **THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS.** You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: <i>John Kinsey</i>	Date:
Print Name of Patient/Plan Member's Representative: <i>Robert Young</i>	Relationship to Patient/Plan Member: <i>Attorney</i>

Revised 3/2003

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: Kelly A. Kirby	Birth Date: 62	Social Security No.: 1159
Persons or Organizations Authorized to Disclose the Information: St. Thomas Hospital Saint Thomas Network Saint Thomas Health Saint Thomas Medical Clinic	Persons or Organizations Authorized to Receive the Information: Saint Thomas Outpatient Neurosurgical Center, LLC	

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: 04/20/14 Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
X All PHI in medical record X Admission form X Dictation reports X Physician orders X Intake/outtake X Clinical Test X Medication Sheets		X Operative Information X Cath lab X Special test/therapy X Rhythm Strips X Nursing Information X Transfer forms X ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet X Itemized bill: X UB-92: X Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. (Initial) If not applicable, check here.

I understand that:

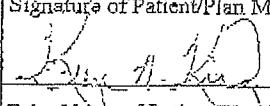
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
5. I understand that my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: 	Date: 4-29-13
Print Name of Patient/Plan Member's Representative: Kelly A. Kirby	Relationship to Patient/Plan Member: Self

LIMITED AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION OR RECORDS

By signing below, I hereby request and authorize the Health Care Provider identified below to disclose certain information (the "Information") as provided in this Authorization.

Information To Be Used Or Disclosed

Patient Name: Joshua Luke Kirkwood Patient Identifier: DOB: 1989

Description of Information: Any and all medical information and records, or true and correct copies thereof, in your possession, custody or control, including, but not limited to, medical histories, records, reports, summaries; diagnosis, prognoses, records of treatment and medication ordered and/or given, entries, letters or correspondence to other physicians, electrocardiograms, x-ray films and reports, ultrasounds, diagnostic imaging studies, laboratory data and records, pathological reports, slides and specimens, prescription records, insurance records, bills or statements of account, incident reports, birth certificates, death certificates and all other written or graphic data prepared, kept, made or maintained in your possession, custody or control and summaries of injuries, treatment and prognosis, if requested, that pertain to the Patient. THIS AUTHORIZATION DOES NOT AUTHORIZE VERBAL COMMUNICATIONS WITH THE REFERENCED INDIVIDUAL OR ORGANIZATION.

Persons Or Organizations Authorized To Disclose The Information

Health Care Provider(s):

Saint Thomas Outpatient Neurosurgical Center, LLC, Howell Allen Clinic, a Professional Corporation, Saint Thomas Network
Saint Thomas Health, St. Thomas Hospital, John Spooner, M.D., John Weeks Culclasure, M.D., Debra V. Schamberg, R.N.

I authorize the Health Care Provider(s) and its employees and agents to disclose the Information as provided in this Authorization. A photostatic copy of this Authorization is to be considered as effective as the original. I understand that I am not required to sign this Authorization. The Health Care Provider will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization.

Persons or Organizations Authorized to Receive the Information

Saint Thomas Outpatient Neurosurgical Center, LLC or any representative, attorney or investigator from said organization, c/o Gregory B. Lanford, M.D., registered agent for service of process, 2011 Murphy Avenue, Suite 301, Nashville, TN 37203-2023 or Suite 901, 4230 Harding Pike, Nashville, TN 37205-2013

Purpose of the Requested Use or Disclosure

Health care liability claim.

Expiration and Revocation of This Authorization

Expiration Date or Event: Conclusion of litigation.

I understand that I may revoke this Authorization at any time prior to the expiration date or event, but that my revocation will not have any affect on actions taken by the Health Care Provider, its employees or agents before they received my revocation. Should I desire to revoke this Authorization, I must send written notice to the Health Care Provider at the following address:

I understand that I may see and copy the Information if I ask for it. I understand that any Information released may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy law or regulations.



3/12/13

Signature (Patient)

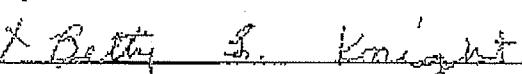
Date

Signature (Authorized Representative) Date

Signature (Witness)

Relationship to Patient

AUTHORIZATION FOR RECEIVE OF PROTECTED HEALTH INFORMATION (PHI)

Section A - This section must be completed for all authorizations.					
Patient/Plan Member Name: Betty L. Knight		Birth Date:	6/30	Social Security No.: 1-1585	
Persons or Organizations Authorized to Disclose the Information:		Persons or Organizations Authorized to Receive the Information:			
St. Thomas Hospital Saint Thomas Network Saint Thomas Health Saint Thomas Medical Clinic		Saint Thomas Outpatient Neurosurgical Center, LLC			
This authorization will expire on the following: (Fill in the Date or the Event but not both.) Date: 04/20/14 Event:					
Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121					
Description of information to be used or disclosed					
Is this request for psychotherapy notes? <input type="checkbox"/> Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. <input type="checkbox"/> No, then you may check as many items below as you need.					
Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery info. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	
I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. 131K (Initial) If not applicable, check here. <input type="checkbox"/>					
I understand that: <ol style="list-style-type: none"> I may refuse to sign this authorization and that it is strictly voluntary. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. My attorney will receive copies of all records received through this authorization. I, through my attorney, will get a copy of this form after I sign it. A photostatic copy of this Authorization is to be considered as effective as the original. 					
REVIEWER: THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEY. You may furnish the law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a facsimile copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.					
I have read the above and authorize the disclosure of the protected health information as stated.					
Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:				Date:	
				4/11/13	
Print Name of Patient/Plan Member's Representative:				Relationship to Patient/Plan Member:	
Betty L. Knight				Self	

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: Carole B. Koonce	Birth Date: /39	Social Security No.: 9922
Persons or Organizations Authorized to Disclose the Information: St. Thomas Hospital Saint Thomas Network Saint Thomas Health Saint Thomas Medical Clinic	Persons or Organizations Authorized to Receive the Information: Saint Thomas Outpatient Neurosurgical Center, LLC	

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: 04/20/14

Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. CBK (Initial) If not applicable, check here.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: <u>Carole B. Koonce</u>	Date: <u>3/22/2013</u>
Print Name of Patient/Plan Member's Representative: Carole B. Koonce	Relationship to Patient/Plan Member: Self

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: Charles Lankford	Birth Date: 1937	Social Security No. (optional):	
Provider's/Health Plan's Name: St. Thomas Hospital	Recipient's Name:		
Provider's/Health Plan's Address: 4220 Harding Road Nashville, TN 37205	Address 1:		
	Address 2:		
	City:	State:	Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: April 1, 2014

Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s)
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath Lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input checked="" type="checkbox"/> Labor/delivery sum. <input checked="" type="checkbox"/> OB nursing assess <input checked="" type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill <input checked="" type="checkbox"/> UB-92 <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. (Initial) If not applicable, check here.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redislosed.
5. I understand that my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. **THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS.** You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:

Charles Lankford

Date:

Print Name of Patient/Plan Member's Representative:

Robert Young

Relationship to Patient/Plan Member:

Attorney

Revised 3/2003

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: Sondra R. Lemberg	Birth Date: 5/4/2	Social Security No.: 460-76-1607
Persons or Organizations Authorized to Disclose the Information: St. Thomas Hospital Saint Thomas Network Saint Thomas Health Saint Thomas Medical Clinic	Persons or Organizations Authorized to Receive the Information: Saint Thomas Outpatient Neurosurgical Center, LLC	

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: 04/20/14

Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. S R L (Initial) If not applicable, check here.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

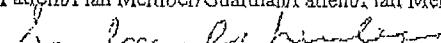
Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:



Date:

2/21/12

Print Name of Patient/Plan Member's Representative:

Sondra R. Lemberg

Relationship to Patient/Plan Member:

Self

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: Patricia S. Lodowski	Birth Date: 1/45	Social Security No.: 4-9883
Persons or Organizations Authorized to Disclose the Information: St. Thomas Hospital Saint Thomas Network Saint Thomas Health Saint Thomas Medical Clinic	Persons or Organizations Authorized to Receive the Information: Saint Thomas Outpatient Neurosurgical Center, LLC	

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: 04/20/14

Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. P.S. (Initial) If not applicable, check here.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & EVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: <i>Patricia S. Lodowski</i>	Date: 3/28/2013
Print Name of Patient/Plan Member's Representative: Patricia S. Lodowski	Relationship to Patient/Plan Member: Self

APR 24 2013 7:55AM
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations.

Patient/Plan Member Name: Eddie C. Lovelace	Birth Date: 1/34	Social Security No.: 4889
Persons or Organizations Authorized to Disclose the Information: St. Thomas Hospital Saint Thomas Network Saint Thomas Health Saint Thomas Medical Clinic	Persons or Organizations Authorized to Receive the Information: Saint Thomas Outpatient Neurosurgical Center, I.I.C	

This authorization will expire on the following: (Fill in the Date or the Event, but not both.)

Date: 04/20/14

Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath Lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. J.J. L. (Initial) If not applicable, check here.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

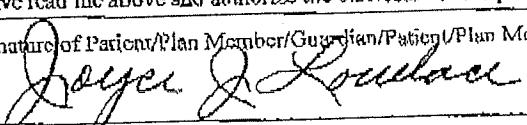
Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Beta-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE, 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:



Date:

03/21/2013

Print Name of Patient/Plan Member's Representative:

Joyce J. Lovelace

Relationship to Patient/Plan Member:

Wife

LIMITED AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION OR RECORDS

By signing below, I hereby request and authorize the Health Care Provider identified below to disclose certain information (the "Information") as provided in this Authorization.

Information To Be Used Or Disclosed

Patient Name: Mary Neal Martin Patient Identifier: DOB: 1923

Description of Information: Any and all medical information and records, or true and correct copies thereof, in your possession, custody or control, including, but not limited to, medical histories, records, reports, summaries, diagnosis, prognoses, records of treatment and medication ordered and/or given, entries, letters or correspondence to other physicians, electrocardiograms, x-ray films and reports, ultrasounds, diagnostic imaging studies, laboratory data and records, pathological reports, slides and specimens, prescription records, insurance records, bills or statements of account, incident reports, birth certificates, death certificates and all other written or graphic data prepared, kept, made or maintained in your possession, custody or control and summaries of injuries, treatment and prognosis, if requested, that pertain to the Patient. THIS AUTHORIZATION DOES NOT AUTHORIZE VERBAL COMMUNICATIONS WITH THE REFERENCED INDIVIDUAL OR ORGANIZATION.

Persons Or Organizations Authorized To Disclose The Information

Health Care Provider: Saint Thomas Outpatient Neurosurgical Center, LLC; Howell Allen Clinic A Professional Corporation; St. Thomas Hospital; John Weeks Culclasure, M.D.; Debra V. Schamberg, R.N.

I authorize the Health Care Provider(s) and its employees and agents to disclose the Information as provided in this Authorization. A photostatic copy of this Authorization is to be considered as effective as the original. I understand that I am not required to sign this Authorization. The Health Care Provider will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization.

Persons or Organizations Authorized to Receive the Information

Howell Allen Clinic A Professional Corporation or any representative, attorney or investigator from said organization, c/o Gregory B. Lanford, M.D., 2011 Murphy Ave, Ste 301, Nashville, TN 37203-2023.

Purpose of the Requested Use or Disclosure

At the request of the undersigned

Expiration and Revocation of This Authorization

Expiration Date or Event: 10/30/2013

I understand that I may revoke this Authorization at any time prior to the expiration date or event, but that my revocation will not have any affect on actions taken by the Health Care Provider, its employees or agents before they received my revocation. Should I desire to revoke this Authorization, I must send written notice to the Health Care Provider at the following address:

I understand that I may see and copy the Information if I ask for it. I understand that any Information released may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy law or regulations.

Signature (Patient)

Date

Signature (Authorized Representative) Date

Patricia M. Martin 4/30/2013

Signature (Witness)

Relationship to Patient

Daughter

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: Herman M. Mathias	Birth Date: 3/36	Social Security No.: 4-2243
Persons or Organizations Authorized to Disclose the Information: St. Thomas Hospital Saint Thomas Network Saint Thomas Health Saint Thomas Medical Clinic	Persons or Organizations Authorized to Receive the Information: Saint Thomas Outpatient Neurosurgical Center, LLC	

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: 04/20/14 Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. MM (Initial) If not applicable, check here.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: <i>Herman M. Mathias</i>	Date: 4-12-13
Print Name of Patient/Plan Member's Representative: Herman M. Mathias	Relationship to Patient/Plan Member: Self

APR. 16, 2013 9:32AM AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: Patricia C. McCulloch	Birth Date: 3/42	Social Security No.: 5-0297
Persons or Organizations Authorized to Disclose the Information: St. Thomas Hospital Saint Thomas Network Saint Thomas Health Saint Thomas Medical Clinic	Persons or Organizations Authorized to Receive the Information: Saint Thomas Outpatient Neurosurgical Center, LLC	

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: 04/20/14

Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
X All PHI in medical record X Admission form X Dictation reports X Physician orders X Intake/outtake X Clinical Test X Medication Sheets		X Operative Information X Cath lab X Special test/therapy X Rhythm Strips X Nursing Information X Transfer forms X ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet X Itemized bill: X UB-92: X Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. PCM (Initial) If not applicable, check here.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:

Date:

Patricia C. McCulloch

3/21/13

Print Name of Patient/Plan Member's Representative:

Relationship to Patient/Plan Member:

Patricia C. McCulloch

Self

LIMITED AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION OR RECORDS

By signing below, I hereby request and authorize the Health Care Provider identified below to disclose certain information (the "Information") as provided in this Authorization.

Information To Be Used Or Disclosed

Patient Name: Basil McElwee, Jr. Patient Identifier: DOB: 1/1939

Description of Information: Any and all medical information and records, or true and correct copies thereof, in your possession, custody or control, including, but not limited to, medical histories, records, reports, summaries, diagnosis, prognoses, records of treatment and medication ordered and/or given, entries, letters or correspondence to other physicians, electrocardiograms, x-ray films and reports, laboratory data and records, pathological reports, slides and specimens, insurance records, bills or statements of account, incident reports, and all other written or graphic data prepared, kept, made or maintained in your possession, custody or control and summaries of injuries, treatment and prognosis, if requested, that pertain to the Patient.

THIS AUTHORIZATION DOES NOT AUTHORIZE VERBAL COMMUNICATIONS WITH THE REFERENCED INDIVIDUAL(S) OR ORGANIZATION(S).

Persons or Organizations Authorized to Disclose the Information

Health Care Provider(s): Saint Thomas Outpatient Neurosurgical Center, LLC, Howell Allen Clinic, a Professional Corporation, Saint Thomas Network, Saint Thomas Health, St. Thomas Hospital, Scott C. Standard, M.D., Rachel C. Rome, M.D., John Weeks Culclasure, M.D., Debra V. Schamberg, R.N.

I authorize the Health Care Provider(s) and its employees and agents to disclose the information as provided in this Authorization. A photostatic copy of this Authorization is to be considered as effective as the original. I understand that I am not required to sign this Authorization. The Health Care Provider will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization.

Persons or Organizations Authorized to Receive the Information

John Weeks Culclasure, M.D., or his representative, attorney or investigator, Howell Allen Clinic, 2011 Murphy Ave, Ste. 301, Nashville, TN 37203 or Saint Thomas Outpatient Neurosurgical Center, Suite 901 4230 Harding Pike, Nashville, TN 37205-2013

Purpose of the Requested Use or Disclosure

Healthcare liability claim.

Expiration and Revocation of This Authorization

Expiration Date or Event: Conclusion of litigation.

I understand that I may revoke this Authorization at any time prior to the expiration date or event, but that my revocation will not have any affect on actions taken by the Health Care Provider, its employees or agents before they received my revocation. Should I desire to revoke this Authorization, I must send written notice to the Health Care Provider at the following address:

I understand that I may see and copy the Information if I ask for it. I understand that any Information released may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy law or regulations.

Basil McElwee 4/9/13
Signature (Patient) Date

Signature (Authorized Representative) Date

Belle Sayer Laywood 4/9/13
Signature (Witness)

Relationship to Patient

AUTHORIZATION FOR RECEIve OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: Mary E. McKee	Birth Date: 3/40	Social Security No.: 14688
Persons or Organizations Authorized to Disclose the Information: St. Thomas Hospital Saint Thomas Network Saint Thomas Health Saint Thomas Medical Clinic	Persons or Organizations Authorized to Receive the Information: Saint Thomas Outpatient Neurosurgical Center, LLC	

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: 04/20/14

Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
X All PHI in medical record X Admission form X Dictation reports X Physician orders X Intake/outtake X Clinical Test X Medication Sheets		X Operative Information X Cath Lab X Special test/therapy X Rhythm Strips X Nursing Information X Transfer forms X ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet X Itemized bill: X UB-92: X Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. M.E.M. (Initial) If not applicable, check here.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: <u>Mary E. McKee</u>	Date: <u>3/25/2013</u>
Print Name of Patient/Plan Member's Representative: Mary E. McKee	Relationship to Patient/Plan Member: Self

HIPAA

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: <i>Joyce P. McKinney</i>	Birth Date: - 1939	Social Security No. - 6954
Provider's/Health Plan's Name & Address: <i>See Attached</i>	Recipient's Name: Dr. John W. Culclasure Address 1: Saint Thomas Outpatient Neurosurgical Center Address 2: 4230 Harding Road, Ste. 901 City: Nashville, TN 37205	State: Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: Event: Conclusion of Litigation

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
<input checked="" type="checkbox"/> All PHU in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input checked="" type="checkbox"/> Labor/delivery sum. <input checked="" type="checkbox"/> OB nursing assess <input checked="" type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input checked="" type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. (Initial) If not applicable, check here.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by the above named recipient for which I am granting my authorization.

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above named recipient shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel William D. Vines, III, Butler, Vines & Babb, PLLC, 2701 Kingston Pike, Knoxville, TN 37919, within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated:

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:

Date:

Joyce P. McKinney
Print Name of Patient/Plan Member's Representative:

6-12-13

Relationship to Patient/Plan Member:

Apr. 29, 2013 11:25AM

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: Mary L. Meeker	Birth Date: 1/57	Social Security No.: -9595
Persons or Organizations Authorized to Disclose the Information: St. Thomas Hospital Saint Thomas Network Saint Thomas Health Saint Thomas Medical Clinic	Persons or Organizations Authorized to Receive the Information: Saint Thomas Outpatient Neurosurgical Center, LLC	

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: 04/20/14

Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
X All PHI in medical record X Admission form X Dictation reports X Physician orders X Intake/outtake X Clinical Test X Medication Sheets		X Operative Information X Cath lab X Special test/therapy X Rhythm Strips X Nursing Information X Transfer forms X ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet X Itemized bill: X UB-92: X Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. (Initial) If not applicable, check here.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: 	Date: 4-12-2013
Print Name of Patient/Plan Member's Representative: Mary L. Meeker	Relationship to Patient/Plan Member: Self

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: <i>Melanie Miller</i>	Birth Date: 177	Social Security No. (optional): <i>7-2284</i>
Provider's/Health Plan's Name:	Recipient's Name:	
Provider's/Health Plan's Address:	Address 1:	
	Address 2:	
	City:	State:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: *April 1, 2014*

Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input type="checkbox"/> All PHI in medical record <input type="checkbox"/> Admission form <input type="checkbox"/> Dictation reports <input type="checkbox"/> Physician orders <input type="checkbox"/> Intake/outtake <input type="checkbox"/> Clinical Test <input type="checkbox"/> Medication Sheets		<input type="checkbox"/> Operative Information <input type="checkbox"/> Cath lab <input type="checkbox"/> Special test/therapy <input type="checkbox"/> Rhythm Strips <input type="checkbox"/> Nursing Information <input type="checkbox"/> Transfer forms <input type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB/nursing assess <input type="checkbox"/> Postpartum flow sheet <input type="checkbox"/> Itemized bill <input type="checkbox"/> UB-92 <input type="checkbox"/> Other: all diagnostic films, x-rays, MRI, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. (Initial) If not applicable, check here.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
5. I understand that my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. **THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEY.** You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:

Date:

5/28/13

Print Name of Patient/Plan Member's Representative:

Relationship to Patient/Plan Member:

Attorney

Revised 3/2003

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: Stella M. Miller	Birth Date: 4/28	Social Security No.: 0296
Persons or Organizations Authorized to Disclose the Information: St. Thomas Hospital Saint Thomas Network Saint Thomas Health Saint Thomas Medical Clinic	Persons or Organizations Authorized to Receive the Information: Saint Thomas Outpatient Neurosurgical Center, LLC	

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: 04/20/14

Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
X All PHI in medical record X Admission form X Dictation reports X Physician orders X Intake/outtake X Clinical Test X Medication Sheets		X Operative Information X Cath lab X Special test/therapy X Rhythm Strips X Nursing Information X Transfer forms X ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet X Itemized bill: X UB-92: X Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. S. M. Miller (Initial) If not applicable, check here.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: <i>Stella M. Miller</i>	Date: 3-22-13
Print Name of Patient/Plan Member's Representative: Stella M. Miller	Relationship to Patient/Plan Member: Self

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PH)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: <i>Dorothy Nascer</i>	Birth Date: 1/45	Social Security No. (401/601): -0188			
Provider's/Health Plan's Name:	Recipient's Name:				
Provider's/Health Plan's Address:	Address 1: -	Address 2: -			
	City: -	State: -			
		Zip: -			
This authorization will expire on the following: (Fill in the Date of the Event but not both.) Date: April 1, 2014 Event:					
Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121					
Description of information to be used or disclosed					
Is this request for psychotherapy notes? <input type="checkbox"/> Yes, then this is the only item you may request on this authorization. <input type="checkbox"/> No, then you may check as many items below as you need. You must submit another authorization for other items below.					
Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input type="checkbox"/> Admission form <input type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input type="checkbox"/> Path Lab <input type="checkbox"/> Special test/therapy <input type="checkbox"/> Rhythm Strips <input type="checkbox"/> Nursing Information <input type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery room <input type="checkbox"/> OB nursing notes <input type="checkbox"/> Post-partum flow sheet <input type="checkbox"/> Itemized bill <input checked="" type="checkbox"/> UB-92 <input type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. *[initial]* If not applicable, check here.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by the office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Parent/Plan Member Representative:

Dorothy Nascer
 Print Name of Patient/Plan Member's Representative: *Robert Young*

Date:

5/20/13

Relationship to Patient/Plan Member:

Attorney

Revised 3/2003

Apr. 29, 2013 11:18AM

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: Janet M. Noble	Birth Date: 45	Social Security No.: 5419
Persons or Organizations Authorized to Disclose the Information: St. Thomas Hospital Saint Thomas Network Saint Thomas Health Saint Thomas Medical Clinic	Persons or Organizations Authorized to Receive the Information: Saint Thomas Outpatient Neurosurgical Center, LLC	

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: 04/20/14

Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
X All PHI in medical record X Admission form X Dictation reports X Physician orders X Intake/outtake X Clinical Test X Medication Sheets		X Operative Information X Cath lab X Special test/therapy X Rhythm Strips X Nursing Information X Transfer forms X ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet X Itemized bill: X UB-92: X Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. S. M. Noble (Initial) If not applicable, check here.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

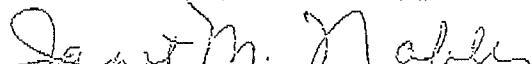
Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:



Date:

March 27, 2013

Print Name of Patient/Plan Member's Representative:

Janet M. Noble

Relationship to Patient/Plan Member:

Self

LIMITED AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION OR RECORDS

By signing below, I hereby request and authorize the Health Care Provider identified below to disclose certain information (the "Information") as provided in this Authorization.

Information To Be Used Or Disclosed

Patient Name: Joseph M. Pellicone Patient Identifier: DOB: 1934

Description of Information: Any and all medical information and records, or true and correct copies thereof, in your possession, custody or control, including, but not limited to, medical histories, records, reports, summaries, diagnosis, prognoses, records of treatment and medication ordered and/or given, entries, letters or correspondence to other physicians, electrocardiograms, x-ray films and reports, ultrasounds, diagnostic imaging studies, laboratory data and records, pathological reports, slides and specimens, prescription records, insurance records, bills or statements of account, incident reports, birth certificates, death certificates and all other written or graphic data prepared, kept, made or maintained in your possession, custody or control and summaries of injuries, treatment and prognosis, if requested, that pertain to the Patient. THIS AUTHORIZATION DOES NOT AUTHORIZE VERBAL COMMUNICATIONS WITH THE REFERENCED INDIVIDUAL OR ORGANIZATION.

Persons Or Organizations Authorized To Disclose The Information

Health Care Provider: Saint Thomas Outpatient Neurosurgical Center, LLC; Howell Allen Clinic A Professional Corporation; John Weeks Culclasure, M.D.; Debra V. Schamberg, R.N.

I authorize the Health Care Provider(s) and its employees and agents to disclose the Information as provided in this Authorization. A photostatic copy of this Authorization is to be considered as effective as the original. I understand that I am not required to sign this Authorization. The Health Care Provider will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization.

Persons or Organizations Authorized to Receive the Information

Howell Allen Clinic A Professional Corporation or any representative, attorney or investigator from said organization, c/o Gregory B. Lanford, M.D., 2011 Murphy Ave, Ste 301, Nashville, TN 37203-2023.

Purpose of the Requested Use or Disclosure

Legal

Expiration and Revocation of This Authorization

Expiration Date or Event: 9/27/13

I understand that I may revoke this Authorization at any time prior to the expiration date or event, but that my revocation will not have any affect on actions taken by the Health Care Provider, its employees or agents before they received my revocation. Should I desire to revoke this Authorization, I must send written notice to the Health Care Provider at the following address:

I understand that I may see and copy the Information if I ask for it. I understand that any Information released may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy law or regulations.

Joseph M. Pellicone
Signature (Patient)

3/27/13
Date

Signature (Authorized Representative) Date

Signature (Witness)

Relationship to Patient

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: Paul H. Pelters	Birth Date: 45	Social Security No.: 5028
Persons or Organizations Authorized to Disclose the Information: St. Thomas Hospital Saint Thomas Network Saint Thomas Health Saint Thomas Medical Clinic	Persons or Organizations Authorized to Receive the Information: Saint Thomas Outpatient Neurosurgical Center, LLC	

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: 04/20/14

Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. PHP (Initial) If not applicable, check here.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

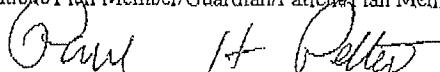
Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:



Date:

3-15-13

Print Name of Patient/Plan Member's Representative:

Paul H. Pelters

Relationship to Patient/Plan Member:

Self

DRAFT USE AT YOUR OWN RISK
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations					
Patient/Plan Member Name: <i>Ken Pierce</i>	Birth Date: <i>60</i>	Social Security No. (optional): <i>1-3398</i>			
Provider's/Health Plan's Name:	Recipient's Name:				
Provider's/Health Plan's Address:	Address 1: <i></i>				
	Address 2: <i></i>				
	City: <i></i>	State: <i></i>	Zip: <i></i>		
This authorization will expire on the following: (Fill in the Date or the Event but not both.) Date: April 1, 2014 Event:					
Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121					
Description of information to be used or disclosed					
Is this request for psychotherapy notes? <input type="checkbox"/> Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. <input type="checkbox"/> No, then you may check as many items below as you need.					
Description: <input checked="" type="checkbox"/> All PHI in medical record <input type="checkbox"/> Admission form <input type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input type="checkbox"/> Medication Sheets	Date(s):	Description: <input checked="" type="checkbox"/> Operative Information <input type="checkbox"/> Cath lab <input type="checkbox"/> Special test/therapy <input type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input type="checkbox"/> Transfer forms <input type="checkbox"/> ER Information	Date(s):	Description: <input type="checkbox"/> Labor/delivery sum. <input checked="" type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	Date(s)
I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. <i>K</i> (Initial) If not applicable, check here. <input type="checkbox"/>					
I understand that: 1. I may refuse to sign this authorization and that it is strictly voluntary. 2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redislosed. 5. I understand that my attorney will receive copies of all records received through this authorization. 6. I, through my attorney, will get a copy of this form after I sign it.					
Section B:					
The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.					
Section C: Signatures					
I have read the above and authorize the disclosure of the protected health information as stated.					
Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: <i>Ken Pierce</i>				Date: <i>5/23/13</i>	
Print Name of Patient/Plan Member's Representative: <i>Larry K. (Ken) Pierce Jr.</i>				Relationship to Patient/Plan Member: <i>Attorney</i>	

Revised 3/2003

AUTORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: Elizabeth A. Price	Birth Date: 53	Social Security No.: 5519
Persons or Organizations Authorized to Disclose the Information: St. Thomas Hospital Saint Thomas Network Saint Thomas Health Saint Thomas Medical Clinic	Persons or Organizations Authorized to Receive the Information: Saint Thomas Outpatient Neurosurgical Center, LLC	

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: 04/20/14 Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
<input checked="" type="checkbox"/> All PHI in medical record		<input checked="" type="checkbox"/> Operative Information		<input type="checkbox"/> Labor/delivery sum.	
<input checked="" type="checkbox"/> Admission form		<input checked="" type="checkbox"/> Cath lab		<input type="checkbox"/> OB nursing assess	
<input checked="" type="checkbox"/> Dictation reports		<input checked="" type="checkbox"/> Special test/therapy		<input type="checkbox"/> Postpartum flow sheet	
<input checked="" type="checkbox"/> Physician orders		<input checked="" type="checkbox"/> Rhythm Strips		<input checked="" type="checkbox"/> Itemized bill;	
<input checked="" type="checkbox"/> Intake/outtake		<input checked="" type="checkbox"/> Nursing Information		<input checked="" type="checkbox"/> UB-92:	
<input checked="" type="checkbox"/> Clinical Test		<input checked="" type="checkbox"/> Transfer forms		<input checked="" type="checkbox"/> Other: all diagnostic	
<input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> ER Information		films, x-rays, MRIs, CAT scans, etc.	
				<input type="checkbox"/> Other:	

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. LCS (Initial) If not applicable, check here.

I understand that:

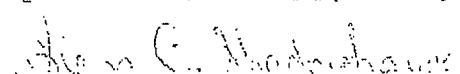
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEY. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a state-numbered copy shall be furnished to my counsel Randall L. Kinnard: KINNARD, CLAYTON & BEVERIDGE, 127 Woodmont Boulevard, Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Minister/Plan Member Representative: 	Date: 3-23-13
--	---------------

Pri: Name of Patient/Plan Member's Representative: Lose C. Shadowhawk	Relationship to Patient/Plan Member: Daughter
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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: J.W. Ragland	Birth Date: /41	Social Security No.: 8512
Persons or Organizations Authorized to Disclose the Information: St. Thomas Hospital Saint Thomas Network Saint Thomas Health Saint Thomas Medical Clinic	Persons or Organizations Authorized to Receive the Information: Saint Thomas Outpatient Neurosurgical Center, LLC	

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: 04/20/14

Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
X All PHI in medical record X Admission form X Dictation reports X Physician orders X Intake/outtake X Clinical Test X Medication Sheets		X Operative Information X Cath lab X Special test/therapy X Rhythm Strips X Nursing Information X Transfer forms X ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet X Itemized bill: X UB-92: X Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. BR (Initial) If not applicable, check here.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: <u>Becky Ragland</u>	Date: <u>3-27-2013</u>
Print Name of Patient/Plan Member's Representative: Becky Ragland	Relationship to Patient/Plan Member: Wife

LIMITED AUTHORIZATION TO DISCLOSE
MEDICAL INFORMATION OR RECORDS

By signing below, I hereby request and authorize the Health Care Provider identified below to disclose certain information (the "Information") as provided in this Authorization.

Information To Be Used Or Disclosed

Patient Name: Kevin R. Richards Patient Identifier: DOB: 1967

Description of Information: Any and all medical information and records, or true and correct copies thereof, in your possession, custody or control, including, but not limited to, medical histories, records, reports, summaries, diagnosis, prognoses, records of treatment and medication ordered and/or given, entries, letters or correspondence to other physicians, electrocardiograms, x-ray films and reports, ultrasounds, diagnostic imaging studies, laboratory data and records, pathological reports, slides and specimens, prescription records, insurance records, bills or statements of account, incident reports, birth certificates, death certificates and all other written or graphic data prepared, kept, made or maintained in your possession, custody or control and summaries of injuries, treatment and prognosis, if requested, that pertain to the Patient. THIS AUTHORIZATION DOES NOT AUTHORIZE VERBAL COMMUNICATIONS WITH THE REFERENCED INDIVIDUAL OR ORGANIZATION.

Persons Or Organizations Authorized To Disclose The Information

Health Care Provider: Saint Thomas Outpatient Neurosurgical Center, LLC; Howell Allen Clinic A Professional Corporation; St. Thomas Hospital; John Weeks Culclasure, M.D.; Debra V. Schamberg, R.N.

I authorize the Health Care Provider(s) and its employees and agents to disclose the Information as provided in this Authorization. A photostatic copy of this Authorization is to be considered as effective as the original. I understand that I am not required to sign this Authorization. The Health Care Provider will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization.

Persons or Organizations Authorized to Receive the Information

Saint Thomas Outpatient Neurosurgical Center, LLC or any representative, attorney or investigator from said organization, c/o Gregory B. Lanford, M.D., 2011 Murphy Ave, Ste 301, Nashville, TN 37203-2023 or Floor 9, 4230 Harding Pike, Nashville, TN 37205-2013.

Purpose of the Requested Use or Disclosure

At the request of the individual

Expiration and Revocation of This Authorization

Expiration Date or Event: 10/21/13

I understand that I may revoke this Authorization at any time prior to the expiration date or event, but that my revocation will not have any affect on actions taken by the Health Care Provider, its employees or agents before they received my revocation. Should I desire to revoke this Authorization, I must send written notice to the Health Care Provider at the following address:

I understand that I may see and copy the Information if I ask for it. I understand that any Information released may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy law or regulations.

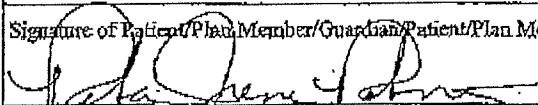
Date

Signature (Authorized Representative) Date .

4/21/13

Relationship to Patient

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations.					
Patient/Plan Member Name: Reba June Robnett		Birth Date: 46	Social Security No.: 481-7		
Persons or Organizations Authorized to Disclose the Information: St. Thomas Hospital Saint Thomas Network Saint Thomas Health Saint Thomas Medical Clinic		Persons or Organizations Authorized to Receive the Information: Saint Thomas Outpatient Neurosurgical Center, LLC			
This authorization will expire on the following: (Fill in the Date or the Event but not both.) Date: 04/20/14 Event:					
Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121					
Description of information to be used or disclosed					
Is this request for psychotherapy notes? <input type="checkbox"/> Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. <input type="checkbox"/> No, then you may check as many items below as you need:					
Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath Lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill <input checked="" type="checkbox"/> UB-92 <input checked="" type="checkbox"/> Other; all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	
I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. <input checked="" type="checkbox"/> (Initial) If not applicable, check here. <input type="checkbox"/>					
I understand that:					
<ol style="list-style-type: none"> I may refuse to sign this authorization and that it is strictly voluntary. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. I understand that my attorney will receive copies of all records received through this authorization. I, through my attorney, will get a copy of this form after I sign it. A photostatic copy of this Authorization is to be considered as effective as the original. 					
<p style="text-align: center;">THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.</p>					
Signature:					
I have read the above and authorize the disclosure of the protected health information as stated.					
Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: 			Date: 3-22-13		
Print Name of Patient/Plan Member's Representative: Reba June Robnett			Relationship to Patient/Plan Member: Self		

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: Annette S. Ruhl	Birth Date: 1/38	Social Security No.: 3951
Persons or Organizations Authorized to Disclose the Information: St. Thomas Hospital Saint Thomas Network Saint Thomas Health Saint Thomas Medical Clinic	Persons or Organizations Authorized to Receive the Information: Saint Thomas Outpatient Neurosurgical Center, LLC	

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: 04/20/14 Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s)
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92; <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. A.S.R. (Initial) If not applicable, check here.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: <i>Annette S. Ruhl</i>	Date: 3-21-13
Print Name of Patient/Plan Member's Representative: Annette S. Ruhl	Relationship to Patient/Plan Member: Self

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: Janet M. Russell	Birth Date: 1/41	Social Security No.: 1629			
Persons or Organizations Authorized to Disclose the Information: St. Thomas Hospital Saint Thomas Network Saint Thomas Health Saint Thomas Medical Clinic	Persons or Organizations Authorized to Receive the Information: Saint Thomas Outpatient Neurosurgical Center, LLC				
This authorization will expire on the following: (Fill in the Date or the Event but not both.) Date: 04/20/14 Event:					
Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121					
Description of information to be used or disclosed					
Is this request for psychotherapy notes? <input type="checkbox"/> Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. <input type="checkbox"/> No, then you may check as many items below as you need.					
Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> X ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. JM (Initial) If not applicable, check here.

I understand that:

^{✓ 4-12-13}

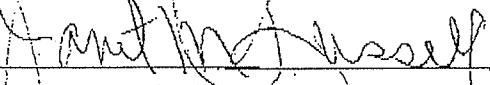
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redislosed.
5. I understand that my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: 	Date: <u>4-12-13</u>
Print Name of Patient/Plan Member's Representative: Janet M. Russell	Relationship to Patient/Plan Member: Self

AUTORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all authorizations.

Patient/Plan Member Name: Thomas W. Rybinski	Birth Date: 1/56	Social Security No.: 44-8468
Persons or Organizations Authorized to Disclose the Information:		Persons or Organizations Authorized to Receive the Information:
St. Thomas Hospital Saint Thomas Network Saint Thomas Health Saint Thomas Medical Clinic	Saint Thomas Outpatient Neurosurgical Center, LLC	

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: 04/20/14

Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath Lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess. <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92; <input type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. SCR (Initial) If not applicable, check here.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:

Silva Colette Rybinski

Date:

3/20/13

Print Name of Patient/Plan Member's Representative:

Colette Rybinski

Relationship to Patient/Plan Member:

Wife

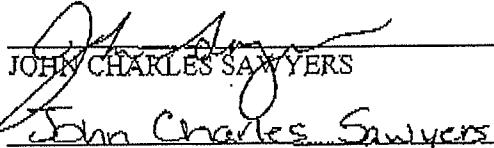
AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION
PURSUANT TO HIPAA C.F.R. 164.512

I authorize the use/disclosure of health information as described below.

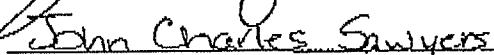
1. Person(s) or class of persons, medical provider or other entity or person authorized to disclose the information: _____
2. Person(s) or class of persons or provider, company or entity to whom the information may be disclosed: ST. THOMAS OUTPATIENT NEUROSURGICAL CENTER, LLC
3. I understand that this may include information relating to acquired immunodeficiency syndrome (AIDS) or infection with HIV (Human Immunodeficiency Virus), psychiatric care, treatment for alcohol and/or drug abuse, and/or genetic testing.
4. Description of information to be disclosed: Medical records and reports, patient information and history forms, x-rays, x-ray report, pathology, pathology reports, insurance records, health care providers' reports and consultations, prescriptions, off-work slips, therapy records, lab reports, notes, tests and billing records and statements.
5. The information will be used/disclosed for the following purposes: For medical providers and any other person or entity to obtain medical records for the purpose of determining what happened to John Charles Sawyers and what persons, manufacturers, distributors, purchasers or entities are responsible for causing injury to Mr. Sawyers and for any other lawful purpose.
6. I understand that the health information described above may be rediscovered and no longer protected by federal and state privacy regulations.
7. I understand that my healthcare or payment for healthcare will not be affected if I refuse to sign this authorization.
8. In consideration of the release of information by _____, in accordance with this request, I hereby release _____, its agents, servants, and employees from any and all claims, demands, or liability of any kind, which might arise of or from the release of such information and the effects thereof.

I understand that I have the right to revoke this authorization in writing at any time by sending written notice of revocation to the person(s), class of persons or provider, company or entity at the above address. I understand my revocation of this authorization will not be effective as to uses and/or disclosures of any information that the person(s) and/or organization have previously provided. A copy of this signed release shall be deemed as effective as if it were the original.

This authorization shall expire two years from the date of its execution.



JOHN CHARLES SAWYERS



John Charles Sawyers

DOB: /1949
S.S. NO: -3457

DATE: 6-10-13

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: Jimmy M. Scott	Birth Date: 1/48	Social Security No.: -6887
Persons or Organizations Authorized to Disclose the Information: St. Thomas Hospital Saint Thomas Network Saint Thomas Health Saint Thomas Medical Clinic	Persons or Organizations Authorized to Receive the Information: Saint Thomas Outpatient Neurosurgical Center, LLC	

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: 04/20/14

Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input checked="" type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill <input checked="" type="checkbox"/> UB-92 <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. JMM (Initial) If not applicable, check here.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE, 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:

Date:

3-23-13

Print Name of Patient/Plan Member's Representative:

Relationship to Patient/Plan Member:

Jimmy M. Scott

Jimmy M. Scott

Self

Authorization for Release of Medical Records and Protected Health Information

TO:

I, Harold Sellers, in compliance with the newly instituted requirements of HIPAA, hereby authorize and request Saint Thomas Outpatient Neurosurgical Center, LLC, Saint Thomas Network, Saint Thomas Health, St. Thomas Hospital, and Howell Allen Clinic A Professional Organization to release or disclose to bearer, or permit bearer to view, and/or to furnish bearer with copies of all billing and medical records or other information pertaining to drug prescriptions, hospitalizations, and/or outpatient care related to the treatment of Harold Sellers.

I further authorize you to photocopy and mail all documents, records, laboratory results, prescription records, or other medical information to:

Saint Thomas Outpatient Neurosurgical Center, LLC
c/o **Gregory B. Lanford M.D.**
2011 Murphy Avenue
Suite 301
Nashville, TN 37203-2023

This authorization will expire one year from the date it was signed, unless revoked sooner. I understand that I may revoke this authorization in writing at any time, to the extent that disclosure has not already occurred prior to my request for revocation. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that treatment or payment cannot be conditioned on my signing this authorization.

This information will be used for legal investigation purposes. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the rule.

I agree that a photocopy of this authorization be accepted with the same authority as the original.

Dated: 3-18-13

Signed: Howard J. S.

Printed: Harold Sellers

DOB: _____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations.

Patient/Plan Member Name: Harvell A. Settle	Birth Date: /34	Social Security No.: 44862
Persons or Organizations Authorized to Disclose the Information: St. Thomas Hospital Saint Thomas Network Saint Thomas Health Saint Thomas Medical Clinic	Persons or Organizations Authorized to Receive the Information: Saint Thomas Outpatient Neurosurgical Center, LLC	

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: 04/20/14 Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill <input checked="" type="checkbox"/> UB-92 <input type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. H.A.S. (Initial) If not applicable, check here.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEY. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodward Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signature

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: <u>Harvell A. Settle</u>	Date: <u>3-24-13</u>
Print Name of Patient/Plan Member's Representative: Harvell A. Settle	Relationship to Patient/Plan Member: Self

May. 10. 2013 9:52AM

No. 1931 P. 29

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: Lewis R. Sharer	Birth Date: 1/36	Social Security No.: 46008
Persons or Organizations Authorized to Disclose the Information: St. Thomas Hospital Saint Thomas Network Saint Thomas Health Saint Thomas Medical Clinic	Persons or Organizations Authorized to Receive the Information: Saint Thomas Outpatient Neurosurgical Center, LLC	

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: 04/20/14

Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> XER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. LJ (Initial) If not applicable, check here.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
5. I understand that my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

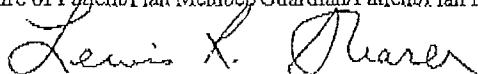
Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

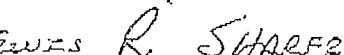
Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:



Date:

3/20/2013

Print Name of Patient/Plan Member's Representative:

Lewis R. Sharer 

Relationship to Patient/Plan Member:

Self

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: Reba M. Skelton	Birth Date: 1/46	Social Security No.: 9734
Persons or Organizations Authorized to Disclose the Information: St. Thomas Hospital Saint Thomas Network Saint Thomas Health Saint Thomas Medical Clinic	Persons or Organizations Authorized to Receive the Information: Saint Thomas Outpatient Neurosurgical Center, LLC	

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: 04/20/14

Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. RS (Initial) If not applicable, check here.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:

Date:

Reba M. Skelton

3-24-13

Print Name of Patient/Plan Member's Representative:

Relationship to Patient/Plan Member:

Reba M. Skelton

Self

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations.

Patient/Plan Member Name: John Jay Slatton	Birth Date: /80	Social Security No.: 5212
Persons or Organizations Authorized to Disclose the Information: St. Thomas Hospital Saint Thomas Network Saint Thomas Health Saint Thomas Medical Clinic	Persons or Organizations Authorized to Receive the Information: Saint Thomas Outpatient Neurosurgical Center, ILC	

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: 04/20/14

Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill <input checked="" type="checkbox"/> UB-92 <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. JJS (Initial) If not applicable, check here.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
5. I understand that my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

Section B: This section must be completed for all Authorizations.

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

Section C: This section must be completed for all Authorizations.

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:

Date:

3-21-13

Print Name of Patient/Plan Member's Representative:

Relationship to Patient/Plan Member:

John Jay Slatton

Self

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: <i>Melaine Stinson</i>	Birth Date: <i>1/6/01</i>	Social Security No. (optional): <i>-1882</i>
Provider's/Health Plan's Name:	Recipient's Name:	
Provider's/Health Plan's Address:	Address 1: <i>F</i>	
	Address 2:	
	City:	State:
		Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: *April 1, 2014*

Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
<input checked="" type="checkbox"/> All PHI in medical record <input type="checkbox"/> Admission form <input type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input type="checkbox"/> Special test/therapy <input type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input checked="" type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. *MS* (Initial) If not applicable, check here.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. **THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS.** You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/ Patient/Plan Member Representative:

Melaine Stinson

Date:

5/17/13

Print Name of Patient/Plan Member's Representative:

Robert Young

Relationship to Patient/Plan Member:

Attorney

Revised 3/2003

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: Anna M. Sullivan	Birth Date: 4/45	Social Security No.: 8928
Persons or Organizations Authorized to Disclose the Information: St. Thomas Hospital Saint Thomas Network Saint Thomas Health Saint Thomas Medical Clinic	Persons or Organizations Authorized to Receive the Information: Saint Thomas Outpatient Neurosurgical Center, LLC	

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: 04/20/14

Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. AM (Initial) If not applicable, check here.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE, 127 Woodmoor Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:



Date:



Print Name of Patient/Plan Member's Representative:

Anna M. Sullivan

Relationship to Patient/Plan Member:

Self

AUTHORIZATION TO DISCLOSE HEALTH INFORMATIONPatient Name Barbara A. TaylorDate of Birth 1949Social Security Number 9448

1. I authorize the use or disclosure of the above named individual's health information as described below:
2. The following individual or organization is authorized to make the disclosure: all medical sources, healthcare providers and treaters.

Address: _____

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

<input type="checkbox"/> physician/nurse assessment	<input type="checkbox"/> medication list	<input type="checkbox"/> history and physical
<input type="checkbox"/> discharge summary	<input type="checkbox"/> laboratory results	<input type="checkbox"/> x-ray and imagingl reports
<input type="checkbox"/> consultation reports	<input checked="" type="checkbox"/> entire record	<input type="checkbox"/> patient information sheet
<input type="checkbox"/> other: _____		

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual or organization: all medical sources, healthcare providers and treaters, and their representatives,

for the purpose of litigation and to comply with Tenn. Code Ann. § 29-26-121.

6. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department and requesting party. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. If I fail to specify an expiration date, event or condition, this authorization will expire in one (1) year. I further authorize the above referenced provider to accept a copy of this Authorization instead of the original of this document, said copy to have full force and effect as though it were the original.
7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Barbara A. Taylor
Signature of Patient or Legal Representative

6-20-13

Date

If Signed by Legal Representative, Relationship to Patient

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: <i>Blake Taylor</i>	Birth Date: 182	Social Security No. (optional): -0293
Provider's/Health Plan's Name:	Recipient's Name:	
Provider's/Health Plan's Address:	Address 1:	
	Address 2:	
	City:	State:
		Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
 Date: April 1, 2014
 Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s)
<input type="checkbox"/> All PNI in medical record <input type="checkbox"/> Admission form <input type="checkbox"/> Dictation reports <input type="checkbox"/> Physician orders <input type="checkbox"/> Intake/outtake <input type="checkbox"/> Clinical Test <input type="checkbox"/> Medication Sheets		<input type="checkbox"/> Operative Information <input type="checkbox"/> Cath lab <input type="checkbox"/> Special test/therapy <input type="checkbox"/> Rhythm Strips <input type="checkbox"/> Nursing Information <input type="checkbox"/> Transfer forms <input type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB/nursing assess <input type="checkbox"/> Postpartum flow sheet <input type="checkbox"/> Itemized bill <input type="checkbox"/> UB-92 <input type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. *BT* (initial) If not applicable, check here.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. **THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS.** You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:
*Blake Taylor*Date:
*5/23/13*Print Name of Patient/Plan Member's Representative:
*Robert Young*Relationship to Patient/Plan Member:
Attorney

Revised 3/2003

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: <i>Donald Turner</i>	Birth Date: <i>1/16/63</i>	Social Security No. (optional): <i>1107</i>
Provider's/Health Plan's Name:	Recipient's Name:	
Provider's/Health Plan's Address:	Address 1: <i>123 Main Street</i>	
	Address 2: <i></i>	
	City: <i>Memphis</i>	State: <i>TN</i>

This authorization will expire on the following (Fill in the Date or the Event but not both.)

Date: *April 1, 2014*

Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input type="checkbox"/> Special test/therapy <input type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input type="checkbox"/> Transfer forms <input type="checkbox"/> ER Information		<input checked="" type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input type="checkbox"/> Itemized bill <input type="checkbox"/> ICD-9-CM <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to each, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. *(RP)* (Initial) If not applicable, check here.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. **THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS.** You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a date-stamped copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: <i>Robert Young</i>	Date: <i>5/23/13</i>
Relationship to Patient/Plan Member: <i>Attorney</i>	

Revised 3/2003

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations.

Patient/Plan Member Name: Steven R. Wanta	Birth Date: 7/56	Social Security No.: 2770
Persons or Organizations Authorized to Disclose the Information: St. Thomas Hospital Saint Thomas Network Saint Thomas Health Saint Thomas Medical Clinic	Persons or Organizations Authorized to Receive the Information: Saint Thomas Outpatient Neurosurgical Center, LEC	

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: 04/20/14 Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s)
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> X Cath lab <input checked="" type="checkbox"/> X Special test/therapy <input checked="" type="checkbox"/> X Rhythm Strips <input checked="" type="checkbox"/> X Nursing Information <input checked="" type="checkbox"/> X Transfer forms <input checked="" type="checkbox"/> X ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input type="checkbox"/> Itemized bill: <input type="checkbox"/> X UB-92: <input type="checkbox"/> X Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. S. R. Wanta (Initial) If not applicable, check here.

I understand that:

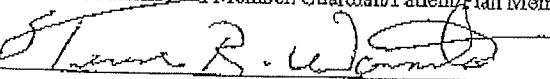
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard, KINNARD, CLAYTON & BEVERIDGE, 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: 	Date: 3-20-13
Print Name of Patient/Plan Member's Representative: Steven R. Wanta	Relationship to Patient/Plan Member: Self

LIMITED AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION OR RECORDS

By signing below, I hereby request and authorize the Health Care Provider identified below to disclose certain information (the "Information") as provided in this Authorization.

Information To Be Used Or Disclosed

Patient Name: Elfreida H. Wiley Patient Identifier: DOB: /1958

Description of Information: Any and all medical information and records, or true and correct copies thereof, in your possession, custody or control, including, but not limited to, medical histories, records, reports, summaries, diagnosis, prognoses, records of treatment and medication ordered and/or given, entries, letters or correspondence to other physicians, electrocardiograms, x-ray films and reports, ultrasounds, diagnostic imaging studies, laboratory data and records, pathological reports, slides and specimens, prescription records, insurance records, bills or statements of account, incident reports, birth certificates, death certificates and all other written or graphic data prepared, kept, made or maintained in your possession, custody or control and summaries of injuries, treatment and prognosis, if requested, that pertain to the Patient. **THIS AUTHORIZATION DOES NOT AUTHORIZE VERBAL COMMUNICATIONS WITH THE REFERENCED INDIVIDUAL OR ORGANIZATION.**

Persons Or Organizations Authorized To Disclose The Information

Health Care Provider(s): Saint Thomas Outpatient Neurosurgical Center, LLC, Howell Allen Clinic, a Professional Corporation, Saint Thomas Network Saint Thomas Health, St. Thomas Hospital, Timothy P. Schoettle, M.D., John Weeks Culclasure, M.D., Debra V. Schamberg, R.N.

I authorize the Health Care Provider(s) and its employees and agents to disclose the Information as provided in this Authorization. A photostatic copy of this Authorization is to be considered as effective as the original. I understand that I am not required to sign this Authorization. The Health Care Provider will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization.

Persons or Organizations Authorized to Receive the Information

Howell Allen Clinic, a Professional Corporation, or any representative, attorney or investigator from said organization c/o Gregory B. Lanford, M.D., registered agent for service of process, 2011 Murphy Avenue, Suite 301, Nashville, TN 37203-2023

Purpose of the Requested Use or Disclosure

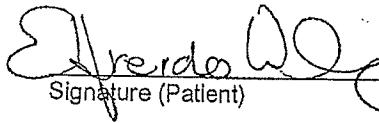
Healthcare liability claim.

Expiration and Revocation of This Authorization

Expiration Date or Event: Conclusion of litigation

I understand that I may revoke this Authorization at any time prior to the expiration date or event, but that my revocation will not have any affect on actions taken by the Health Care Provider, its employees or agents before they received my revocation. Should I desire to revoke this Authorization, I must send written notice to the Health Care Provider at the following address:

I understand that I may see and copy the Information if I ask for it. I understand that any Information released may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy law or regulations.


Signature (Patient)

05/01/2013

Date

Signature (Authorized Representative) Date

Signature (Witness)

Relationship to Patient

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: <i>Kristy Wilkinson</i>	Birth Date: 1/70	Social Security No. (optional): -313	
Provider's/Health Plan's Name:	Recipient's Name:		
Provider's/Health Plan's Address:	Address 1:		
	Address 2:		
	City:	State:	Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: April 1, 2014

Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
<input checked="" type="checkbox"/> All PHI in medical record <input type="checkbox"/> Admission form <input type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath Lab <input type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. *MM* (Initial) If not applicable, check here.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be rediscovered.
5. I understand that my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. **THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS.** You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:
*Kristy Wilkinson*Date:
5/23/13Print Name of Patient/Plan Member's Representative:
*Robert Uyuen*Relationship to Patient/Plan Member:
Attorney

Revised 3/2003

LIMITED AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION OR RECORDS

By signing below, I hereby request and authorize the Health Care Provider identified below to disclose certain information (the "Information") as provided in this Authorization.

Information To Be Used Or Disclosed

Patient Name: Earline T. Williams Patient Identifier: DOB: 1940

Description of Information: Any and all medical information and records, or true and correct copies thereof, in your possession, custody or control, including, but not limited to, medical histories, records, reports, summaries, diagnosis, prognoses, records of treatment and medication ordered and/or given, entries, letters or correspondence to other physicians, electrocardiograms, x-ray films and reports, ultrasounds, diagnostic imaging studies, laboratory data and records, pathological reports, slides and specimens, prescription records, insurance records, bills or statements of account, incident reports, birth certificates, death certificates and all other written or graphic data prepared, kept, made or maintained in your possession, custody or control and summaries of injuries, treatment and prognosis, if requested, that pertain to the Patient. THIS AUTHORIZATION DOES NOT AUTHORIZE VERBAL COMMUNICATIONS WITH THE REFERENCED INDIVIDUAL OR ORGANIZATION.

Persons Or Organizations Authorized To Disclose The Information

Health Care Provider: Saint Thomas Outpatient Neurosurgical Center, LLC; Howell Allen Clinic A Professional Corporation; St. Thomas Hospital; John Weeks Culclasure, M.D.; Debra V. Schamberg, R.N.

I authorize the Health Care Provider(s) and its employees and agents to disclose the information as provided in this Authorization. A photostatic copy of this Authorization is to be considered as effective as the original. I understand that I am not required to sign this Authorization. The Health Care Provider will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization.

Persons or Organizations Authorized to Receive the Information

Saint Thomas Outpatient Neurosurgical Center, LLC or any representative, attorney or investigator from said organization, c/o Gregory B. Lanford, M.D., 2011 Murphy Ave, Ste 301, Nashville, TN 37203-2023 or Floor 9, 4230 Harding Pike, Nashville, TN 37205-2013.

Purpose of the Requested Use or Disclosure

Legal

Expiration and Revocation of This Authorization

Expiration Date or Event: 10/11/13

I understand that I may revoke this Authorization at any time prior to the expiration date or event, but that my revocation will not have any affect on actions taken by the Health Care Provider, its employees or agents before they received my revocation. Should I desire to revoke this Authorization, I must send written notice to the Health Care Provider at the following address:

I understand that I may see and copy the information if I ask for it. I understand that any information released may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy law or regulations.

Signature (Patient)

Date

Signature (Authorized Representative) Date

Earline Williams 4/11/13
50A

Signature (Witness)

Relationship to Patient

AUTORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all authorizations

Patient/Plan Member Name: Annette G. Young	Birth Date: 1/25	Social Security No.: 463-6637
Persons or Organizations Authorized to Disclose the Information: St. Thomas Hospital Saint Thomas Network Saint Thomas Health Saint Thomas Medical Clinic	Persons or Organizations Authorized to Receive the Information: Saint Thomas Outpatient Neurosurgical Center, LLC	

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
 Date: **04/20/14** Event:

Purpose of disclosure: **COMPLIANCE WITH T.C.A. § 29-26-121**

Description of information to be used or disclosed

Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s)
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/vitals <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath Lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum, <input type="checkbox"/> OB nursing assess <input checked="" type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill <input checked="" type="checkbox"/> UB-92 <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. M (Initial) If not applicable, check here.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEY. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a facsimile-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Wedderson Boulevard; Murfreesboro, TN 37135 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Family/Plan Member Representative:

Date:

3-21-13

Print Name of Patient/Plan Member's Representative:

Annette G. Young

Relationship to Patient/Plan Member:

Self

AUTORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (Part 1)

Patient/Plan Member Name: Eden Yerkes	Birth Date: 34	Social Security No.: 1440			
Persons or Organizations Authorized to Disclose the Information: St. Thomas Hospital Saint Thomas Network Saint Thomas Health Saint Thomas Medical Clinic		Persons or Organizations Authorized to Receive the Information: Saint Thomas Outpatient Neurological Center, LLC			
This authorization will expire on the following: (Fill in the Date or the Event but not both.) Date: 04/20/14 Event:					
Purpose of disclosure: COMPLIANCE WITH T.C.A. § 39-26-121					
Description of information to be used or disclosed					
Is this request for psychotherapy notes? <input type="checkbox"/> Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. <input type="checkbox"/> No, then you may check as many items below as you need.					
Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission forms <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intakes/take <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill <input checked="" type="checkbox"/> UB-92 <input type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	
I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. <input checked="" type="checkbox"/> (Initial) If not applicable, check here. <input type="checkbox"/>					
I understand that:					
<ol style="list-style-type: none"> I may refuse to sign this authorization and that it is strictly voluntary. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. I understand that my attorney will receive copies of all records received through this authorization. I, through my attorney, will get a copy of this form after I sign it. A photostatic copy of this Authorization is to be considered as effective as the original. 					
THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEY. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a date-stamped copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37216 within five (5) days after the records are obtained through the use of this authorization.					
I have read the above and authorize the disclosure of the protected health information as stated.					
Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: Eden Yerkes			Date: 3-26-2013		
Print Name of Patient/Plan Member's Representative: Eden Yerkes			Relationship to Patient/Plan Member: Self		

**Authorization for Release of Medical Records and
Protected Health Information**

TO:

I, Adam Ziegler, in compliance with the newly instituted requirements of HIPAA, hereby authorize and request Saint Thomas Outpatient Neurosurgical Center, LLC, Saint Thomas Network, Saint Thomas Health, St. Thomas Hospital, and Howell Allen Clinic A Professional Organization to release or disclose to bearer, or permit bearer to view, and/or to furnish bearer with copies of all billing and medical records or other information pertaining to drug prescriptions, hospitalizations, and/or outpatient care related to the treatment of Adam Ziegler.

I further authorize you to photocopy and mail all documents, records, laboratory results, prescription records, or other medical information to:

Saint Thomas Outpatient Neurosurgical Center, LLC
c/o Gregory B. Lansford M.D.
2011 Murphy Avenue
Suite 301
Nashville, TN 37203-2023

This authorization will expire one year from the date it was signed, unless revoked sooner. I understand that I may revoke this authorization in writing at any time, to the extent that disclosure has not already occurred prior to my request for revocation. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that treatment or payment cannot be conditioned on my signing this authorization.

This information will be used for legal investigation purposes. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the rule.

I agree that a photocopy of this authorization be accepted with the same authority as the original.

Dated: 19 MARCH 2013

Signed: 

Printed: Adam Ziegler

DOB: 1980